

# PROCEEDINGS AND RECOMMENDATIONS OF



**3<sup>rd</sup> REGIONAL CONFERENCE  
OF SEARB, IUHPE**

**PEOPLE'S INVOLVEMENT IN  
HEALTH AND DEVELOPMENT OF  
WOMEN AND CHILDREN**

*HOSTED BY*

**TAMSEARB  
MADRAS**

**20-21-22 JAN 1994**



12240  
CPHE-  
CLIC

## Conference Theme and sub-themes

The main theme of the conference will be "People's Involvement in the Health and Development of Women and Children." The following will be the sub-themes:

1. Involvement of people in the assessment of current status of health and development of women and children from social, cultural, educational, economic and political angles.
2. People's involvement in identification and prioritisation of interventions to promote health and development of women and children during infancy, childhood, adolescence, child-bearing, and old age.
3. People's Involvement - its origin, rationale, needs and approaches barriers, facilitators etc. - for promoting health, and development of women and children.
4. People's involvement in planning, implementing, reviewing programmes aimed at child survival and development, safe motherhood, family welfare (family planning), nutrition, health and development of adolescents, care of the elderly, school health education, occupational health and prevention and control of AIDS.
5. Involvement of people in human resources development for preparing health and allied personnel, community groups, political and administrative leaders and others for the promotion of health and development of women and children.
6. Role of communication and media in promoting people's involvement - interpersonal, group, and mass approaches.
7. People's involvement for promoting inter-sectoral coordination.
8. Role of community groups particularly of women and children as change agents, ways to promote their involvement.
9. Involvement of people in monitoring, evaluation and research (particularly participatory evaluation) of health and development programmes of women and children.



**PROCEEDINGS  
AND  
RECOMMENDATIONS OF**

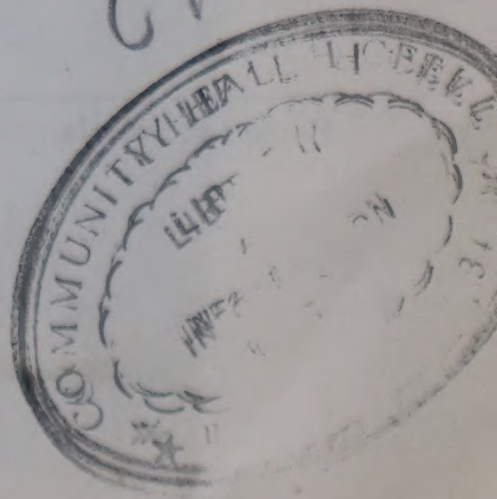


**3<sup>rd</sup> REGIONAL CONFERENCE  
OF SEARB, IUHPE**



**PEOPLE'S INVOLVEMENTS IN  
HEALTH AND DEVELOPMENT OF  
WOMEN AND CHILDREN**

**HOSTED BY  
TAMSEARB AT  
MADRAS  
20-21-22 JAN 1994**





## CONFERENCE ORGANISERS

Regional Director - SEARB : Dr. V. Ramakrishna  
President - TAMSEARB : Dr. A. Ramalingeishwara Rao  
Vice-President - TAMSEARB : Fr. Emmanuel Mariam Pillai  
Secretary - TAMSEARB : Dr. Sumathy S. Rao  
Treasurer - TAMSEARB : Dr. H. Pramila  
Members - TAMSEARB : Dr. N.C. Appavoo

Dr. V. Kapali

Mr. G. Kittu Rao

Dr. P. Krishnamurthy

Dr. V. Natarajan

Dr. P. Padmanabhan

Dr. K.A. Pisharoti

Dr. Paul Kandasamy

Dr. V. Prithivi

Dr. C. Thirugnanasambandham

Mrs. Sarojini

Mr. Tharani Singh

C.P.H.E - C.I.C  
12246  
WH-100N-4

## EDITORIAL COMMITTEE

Dr. K.A. Pisharoti.

Dr. V. Kapali.

Dr. V. Natarajan.

This conference has been financially supported by :  
**DANIDA and UNICEF**



# CONTENTS

## SECTION I

	Page
1. Women's Development - Issues and Experiences <i>Dr. Mrs. Yasodha, Shanmughasundaram.</i>	1
2. People's Involvement in health and development of women and children : Identification and prioritization of interventions : Some issues and recommendations. <i>Dr. Ashok Sahni and Dr. Sudha Xirasagar.</i>	12
3. Community Health Care System A Model for Health in Panchayati Raj. <i>Dr. N.H. Antia.</i>	17
4. Survey of Mothers on their Attitudes and sources of information on infant feeding practices. <i>Lt. Col. P.B. Pillai.</i>	63
5. Nutritional Survey of Preschool Children in Urban ICDS. <i>Wg. Cdr. T.S. Raghuraman, Lt. Col. C.G. Wilson, Lt. Col. Vipin Chandar</i>	72
6. Birth Weight co-relate to mothers age and Parity : One year Urban Hospital Study - Karnataka <i>Abdul Salam, Mohd. S. Akthar, Vidya S. Ugran, Mumtaz A. Lashkari</i>	83
7. Child Labour in Sivakasi.	90

## SECTION II

1. Health Education & Promotion for the School Age Child : An International Perspective. <i>Colin L. Yarham.</i>	97
2. People's Involvement in Programmes aimed at Health and Development of Women and Children in South East Asia. <i>Dr. Saroj S. Jha.</i>	113
3. Community participation in the management of ICDS projects. <i>Prof. B.N. Tandon</i>	135



4. Lessons learnt from the Innovative experiences of community participation in India and their application to people's involvement for health and development of women and children.  
*Dr. Sudha Xirasagar and Dr. Ashok Sahni.* 138
5. Involvement of Women in Achieving Fertility Decline through Income Generation Activities : An Experience from the Women's programs of the Bangladesh Health and Family Planning Sector.  
*Faroque Ahmed.* 158
6. Role of voluntary agencies in promoting People's involvement in health and development of women.  
*Tmt. Nandini Rajendran.* 166
7. Women and Environment Health Programmes Experiences and Recommendations.  
*Anuradha Gadkari.* 174
8. Mobilizing the people for EPI  
- The Bangladesh Experience.  
*Mahboob Shareef.* 200
9. Role of women in decision making process  
A case study on utilisation of primary health services in Madurai District.  
*Dr. J. Prabhu Clement Devadass.* 208
10. Community Involvement in Health subcentre construction :  
*Dr. G. Vittal Raj.* 220
11. Assessment of the impact of nutrition/health education on mothers of school children.  
*D. Malathi Ravindran, Dr. Usha Chandrasekhar* 225
12. Impact of nutrition/health education on farm women.  
*M. Aruna Seralathan, S. Neelakantan* 230
13. Health Education and community participation  
*Dr. T. Jayakumar.* 240



	Page
14. Lessons from some case studies of community based projects. <i>Mrs. Shantha Narayanan.</i>	245
15. Community involvement - TINP Experience <i>Mrs. Annie Valsarajan.</i>	248
16. Community participation for women and child health programmes. <i>Dr. Sumathy S. Rao.</i>	252
17. Impact of Health Education on mothers in a captive population : A Hospital Experience. <i>Dr. A. Parthasarathy, Dr. B. Padmavathi, Dr. Radha Dr. Rajamani Mrs. C. Rajammal Dr. M. Santharam</i>	260

### SECTION III

1. Health Education and Mass Media : How to communicate effectively. <i>Drs. J. Hagendoorn.</i>	265
2. Role of cultural, indigenous media to promote people's involvement for women & child health and development. <i>Dr. N. Murugesan.</i>	270
3. Meeting the critical nutritional needs of under threes in the ARF (Amylase Rich Food) project. <i>Prasadika Rathod.</i>	275
4. Experience of celebrating Nutrition week with Children in schools of Ahmedabad. <i>Ms. Mona Shah.</i>	282
5. A Camp as a Strategy for women's health awareness - Chetna's Experience. <i>Ms. Jyoti Gade.</i>	284
6. Introductory paper on Child to Child Approach. <i>Minaxi Shukla.</i>	290
7. Need of the day : "Sex Education to Adolescents" <i>Ms. Anuja Kak.</i>	296



## SECTION IV

	Page
1. Involvement of people in a longitudinal research program dealing with Human reproduction and growth. <i>Dr. P.S.S. Sundar Rao.</i>	299
2. Participatory approach in population health surveys (A 10 Year experience in lymphatic filariasis). <i>Sakthivel Maruthamuthu, Aravindan M. Theodore, Ambalavanar Iyanar, Abraham Joseph.</i>	302
3. Capacity building through participatory technique : An innovative approach for effective participation of women in hygiene education programmes. <i>O.T. Rema Devi .</i>	311
4. People's involvement in research on Determinants of Female age at marriage. <i>J. Richard, P.S.S. Sunder Rao.</i>	317
5. Participatory monitoring of Family Welfare methods practices in the community mothers. <i>Dr. D. Jegadeesh Ramasamy.</i>	323

## SECTION V

1. Pre Conference Workshop of SEARB, IUHPE Andhra Pradesh Chapter	327
2. Pre Conference Workshop of SEARB, IUHPE Kerala Chapter <i>Dr. K. Balachandrakurup.</i>	334
3. Pre Conference seminar of SEARB, IUHPE Karnataka Chapter.	337
4. Pre Conference Seminar of SEARB, IUHPE Tamil Nadu Chapter <i>Dr. Prithivi.</i>	341
5. 3rd Regional Conference of SEARB	353
6. Inaugural Session	358
7. Recommendations	374
8. Valedictory Speeches.	380
9. Delhi Declaration	394
10. List of Participants	











# WOMEN'S DEVELOPMENT ISSUES AND EXPERIENCES

*Dr. Mrs. Yashodha Shanmugasundaram*

## HEALTH OF WOMEN

Any discussion on health of children will not be meaningful without considering the health status of women. Today there is a world-wide recognition of the fact that women and children as a group, even in the most developed nations suffer a wide variety of disadvantages. There arises a need for organised articulation of their problems and needs. It is a well known fact that women face extra problems throughout their life cycle, starting from sex preferences in infancy, discrimination in feeding practices, biological vulnerability during the reproductive period, the effects of repeated pregnancies, to special problems such as nutritional anaemia and maternal mortality. The low social status of Indian women, their marginal presence in the market economy and the male bias at all levels- social, economic and political are responsible for the grossly inadequate attention paid to women's needs in the strategy for development, and in health planning in particular.

The differences in health status arising from gross neglect and low priority are reflected in the unfavourable sex ratio and high levels of mortality and morbidity and resulting low physical and low economic productivity among women in India. There is a linkage between health and productivity in the special context of women. The sex ratio has been falling from decade to decade; it declined from 972 women per 1000 men in 1901 to 930 women to every 1000 men in 1971. The 1981 census appeared to show that the trend is halted at 933. But the sex ratio continues to be unfavourable to women with 929 in 1991. (Table I) A noteworthy feature is that sex ratio is higher in rural population with 951 and lower at 878 in urban population. The state-wise ratio shows wide variations. Kerala is the only state where women outnumber men - 1040 females per 1000 males (1991). The situation is worse in the case of Uttar Pradesh (882), Haryana (874), Punjab (888), Jammu & Kashmir (923), Assam (925), Nagaland (890), West Bengal (917) and Rajasthan (913), with the ratios being appreciably lower than the national figure of 929.



**Table 1****Sex Ratio and Life Expectancy at birth (census estimation)**

Census	Sex ratio female per 1000 males)	Expectation of life at birth (years)	
		Male	Female
1901	972+	23.63	23.96
1911	964	22.59	23.31
1921	955	19.42	20.91
1931	950+	26.91	26.56
1941	945+	32.09	31.37
1951	946	32.45	31.66
1961	941	41.89	40.45
1971	930	46.40	44.70
1981	934	55.12	54.31
1986-91	929	58.10	59.10
1990-96		60.60	61.70

*Source: Government of India 1984 Health Statistics of India 1984. Delhi: MOHFW Tables 1.1+2.11.*

This imbalance cannot be attributed to the differential patterns of migration, but is probably due to the higher rate of mortality among women in most age groups. In India, unlike in the developed countries, the life expectancy among females has not been lower than among males until 1971 (Vide Table 2), by 1980 the gap appeared to be closing. However average figures are misleading, for the death rates among female children under 4 years of age are distinctly higher than among male children, in all but four states in India, Kerala, Tamil Nadu, Assam and Andhra Pradesh. The mortality rate for female infants in rural areas remains significantly higher than those for males.

**Table 2**  
**Expectation of life at Birth**

	Male	Female	Combined
1981-86	55.6	56.4	56.0
1986-90	58.1	59.1	58.6
1990-96	60.6	61.7	61.2

*Source : Seventh Five Year Plan.*



## **FEMALE MORTALITY AND MORBIDITY**

The WHO estimates that some 5,00,000 women a year worldwide die as a result of complications in pregnancy and childbirth most of which are preventable. Significantly in developing countries 85 per cent of the world's births and 99 per cent of maternal deaths take place. In most developed countries the maternal mortality rates vary from 5 to 30/1,00,000 births. In developing countries it is 10 times higher. To quote from WHO figures mortality rates per 1,00,000 live births are approximately 640 in Africa, 270 in Latin America and 420 in Asia with an average 30 for developed world as a whole. Average figures do not quite reveal the true picture of the situation in certain groups and communities and regions. A comparative study involving 41 teaching centres for a period of 4 years (1978-81) reported 4707 maternal deaths giving a MMR of 720.9/1,00,000 births.

Approximately 1,20,000 women die of maternity related causes in India. The Maternal Mortality Rate (MMR) is 50 times higher in India compared to developed countries. Unlike in developed countries where male death rate exceed female death rate, in India death rates of women in the reproductive period exceed those of men of corresponding ages. It is only after the age of 40 years that male death rates overtake female death rates. Talwalkar (1983) indicates that the maternal mortality rate per 1000 live births in India is 5.0 Corresponding figures for other developing countries (1) are Ecuador (2.10), Kenya (1.90), Tunisia (3.10)., for Sweden (1971), USA (1978) and UK (1980) the figures were 1, 10 and 11 per 1,00,000 live births respectively (2)

A set of inter-related factors, both economic and a socio-cultural underlie these health hazards in pregnancy and delivery and are responsible for the above mortality picture.

### **(I) EARLY AGE AT MARRIAGE AND ADOLESCENT PREGNANCIES**

Mean age at marriage in India is the lowest in the world. This is also responsible for the high population growth rate. In seven decades (1901-1971) the average age at marriage had gone up by just 2 years (from 20.2 to 22.2 years) in the case of males and 4 years (from 13.2 to 17.2 years) in the case of females (13). In the year 1971, 13.6 percent of the girls between 10-14 years were reported to be married in the rural areas, and 3.9 per cent in urban areas, in contravention of the Child Marriage Restraint Act. During 1971-81 decade this has improved to 18.3 years for women and 23.3 for men. There are distinct



regional and class variations (3&4). Risks and obstetric complications are particularly high in early pregnancy (under 16 years of age). In addition, risks to infants from low birth weight and congenital abnormalities are also more frequent. Table 3 indicates the heavy price extracted from women by such preventable conditions as puerperal sepsis, anaemia and abortions, and underlines the need for proper antenatal care and paramedical assistance at childbirth to ensure safe delivery. Maternal Mortality rate (MMR) is a measurable index of the availability and the use of obstetric care.

**Table 3**

**Percentage of Maternal Deaths by Age group due to causes related to child birth and pregnancy (1986) (Rural India)**

Causes	Age Group		
	15-24	25-34	35-44
Abortion	8.9	7.5	6.7
Toxaemia	13.9	8.9	13.3
Anaemia	12.7	19.4	23.4
Bleeding of pregnancy and puerperium	15.2	29.8	20.0
Malposition of child leading to death of mother	3.8	6.0	13.3
Puerperal sepsis	17.7	7.5	13.3
Not classifiable	27.8	20.9	10.0
Total	100.0	100	100

*Source: Survey of causes of Death (Rural) 1982, 1986, 1988  
A Report In GOI, MOHFW, 1985 (a) Table 2.51*

## **II) HIGH INFANT MORTALITY, REPEATED PREGNANCIES AND PROBLEMS RELATED TO PREGNANCIES**

During the prime reproduction age (15-45 years) the average Indian women becomes pregnant about eight times. She may ultimately be left with only 3-5 children due to the high infant and early childhood mortality. The need to produce extra hand to work on the lands and at home, the anticipation of premature death of children and the cultural premium on male off-springs as guarantors of social security in old age, have all contributed to repeated pregnancies and the high birth rate.



However, the devaluing of the female sex means that there is no increase in food intake by women in keeping with the requirements during pregnancy and lactation (5). Nutritional anaemia is one of the major causes of rapid ageing and lowered resistance of young women. Between 60 to 68% of all pregnant women in India are reported to suffer from anaemia. The insufficient intake of food and iron deficient diets combined with excessive demands on women's energy makes anaemia a very common problem and a major cause of female mortality in all age groups (Table 3). The cumulative result of poverty undernutrition and neglect which girls in the countryside suffer, is reflected in their poor adult body -size. Combined with the lack of proper care, it leads to high maternal mortality (3) Low birth weight and prematurity. Major causes of infant mortality are evidence of the poor nutritional status of women.

### **III) EXCESSIVE WORK OF LONG DURATION**

It has been estimated that women perform nearly two thirds of the working hours, receive one-tenth of the world's income and own less than one hundredth of the world's property (2). In India 14-16 hours or nearly two thirds of a woman's day is spent in working (6). A rural field study found the respective energy contribution of men, women and children to be 31 percent, 53 percent and 16 percent. Women spend more hours per day on survival related tasks such as gathering fuel or water, and walking the long distances between the home and resources, and the primitive technology which result in higher calorie expenditure per day in women. Yet the pattern of food consumption remains biased towards the male members of the family.

### **IV) ABORTIONS**

Induced abortion is probably the most widely used method of fertility regulation. Each year 40-70 per 1000 women in the reproductive age have an abortion. According to the year book of the Department of Family Planning and Welfare, the highest percentage of MTP (Medical Termination of Pregnancy) cases performed are due to the failure of contraception, (annual percentage around 47%). This is a clear case of emphasizing the health education aspects of the family planning programmes (8). The number of deaths per 1000 MTPs conducted is reported to be of the order of 0.14. Studies on maternal mortality and morbidity indicate a high incidence of septic abortions, infection associated with abortion and a history of unsuccessful obstetric interference, as major causes of maternal deaths (9).



## INDICATORS OF HEALTH STATUS OF WOMEN ARE :

a. Levels of antenatal care: Only 40-50 per cent of pregnant women at present receive antenatal care. b. Tetanus immunization: Only 20 per cent of pregnant women receive tetanus toxoid, and even among these the immunization is only partial, often with a single dose. c. postnatal care is equally poor among the nursing mothers leading to the complication of post-natal period and poor health. d. Sex discrimination begins at birth and continues in a women's life, from childhood through adulthood to old age. e. Social status of women being what it is, the unique reproductive potential of a female has never been considered as a case for receiving better medical care or better social treatment. f. Female mortality rate reflects the above statement. In 1978, male mortality rate was 120 but female mortality was 131. g. Unskillful midwifery. In the rural areas nearly 70% of the deliveries are domiciliary mostly attended by untrained dais or friends and relatives. The attendant complications are not coped up with and hence poor health of the mother. h. Financial barrier: Low income levels impose serious limitations to have access to medical care. i. Illiteracy: Female literacy rate particularly is an important determinant both for demanding and for providing medical, health and social welfare services.

Excessive mortality and poor health of women in India are the result of the cultural, social and economic factors leading to their undernourishment and malnutrition. Health to many women is the last priority. Access to health care and medical services are not adequate and whatever is provided is not fully utilised by them. Low health status results in increasing gap between men and women in literacy, training for employment and employment status. The long term resultant of the cumulative impact of the above mentioned factors is the continuously declining sex ratio in India. The major causes for permanent impairment in the health status of women are repeated pregnancy, short birth intervals and pregnancies occurring at the extremes of reproductive age and lack of family planning practices, especially in the mid and low income groups. The low literacy level of females accentuates the situation.

In India 50 per cent of all women and 2/3 of all pregnant women are anaemic. During pregnancy it is recommended that she should get 2500 calories but in reality only 1440 calories are available to her. She needs 55 gms of Protein but receives only 37 gms. She needs 40 gms of iron but gets only 18 gms. She needs 1 gm of calcium but receives a mere 0.2 gm.



## ACCESS TO AND UTILISATION OF HEALTH SERVICES HEALTH PROGRAMMES FOR WOMEN

Access to health services is the result of women's status and is a determinant of their health status and productivity. Need for health care, permission to seek the care and the availability of health care services are factors that influence access to health care (10). Data regarding the utilisation of health services by women is extremely limited. The only women-oriented programmes in the health sector are the maternal and child health (MCH) services and to some extent, family planning. Most nutrition programmes have solely focussed on pregnant and lactating women.

Women have less access to health services, not because they are healthier or possess adequate health knowledge, but because their health is of low priority. An examination of records of medical institutions reveals that for every 3 men who avail of these facilities, only one woman does so. Women are constrained by the cumbersome and time consuming procedures in hospital, and the largely male staffing of these facilities. The revised Dais Training Programme and the Community Health Guide (CHG) Scheme, are expected to improve the delivery of basic health service in the rural areas. However, most village panchayats have favoured the selection of male members and not women, to the post of village health workers. The prevalent sex-segregation however prevents the latter from reaching women and children effectively. The Voluntary Health association of India has suggested that every alternative village be posted with one female health worker to take care of the female population in her own, and that of the male CHG's village (11).

Maternal and child Health services were one of the earliest priorities and components of the new health services organisation in Independent India. The enormous dimensions of the health problems of mothers and children had been highlighted in the pre 1947 studies on maternal and infant mortality rates and causes (12). The low levels of health among these two vulnerable groups, the high percentage of deaths due to preventable factors and the urgent need for state intervention, were discussed both in these studies and in the reports of the Sokhey and the Bhore Committee (12,13).

According to the Bhore Committee report, nearly one half of the total deaths at all ages in British India took place among children under 10 years. Of these, nearly a half were among infants under one year,



and 45 to 50 per cent of all infant deaths occurred during the neonatal period. The report put forward the conservative estimate of 200,000 annual deaths among women in the reproductive ages from causes associated with pregnancy and child bearing, and some four million cases of maternal morbidity from the same causes. The Committee recommended that mother and child welfare services form an integral part of the general health services. The services envisaged included early contact of antenatal mothers, follow up throughout pregnancy, attention to hygiene and diet during pregnancy and provision of safe delivery service, as also instruction on birth control. For the child, attention was to be paid to growth, development, nutrition and immunization and the maintenance of weekly weight record.

## **MATERNAL HEALTH SERVICES**

Between 1947 and the launching of the First Five Year Plan, the emphasis was on the expansion of the First Services, the strengthening of Maternal and child Welfare (MCW) centres through WHO and Unicef assistance and the creation of administrative positions in MCW in all the states. The non-availability of trained personnel, the concentration of MCW centres in urban areas were perceived to be the major problems for the delivery of MCH services. There was an overall increase in the health services for infants and children in the First Plan period, when MCH services were integrated into the overall health services to be delivered by primary health centres. The grossly inadequate PHC staff could barely cope with the maternity load (One ANM per 800 births annually in 40 villages). In comparison, the short term programme envisaged by the Bhole Committee was one PHC per 20,000 population, with a staff pattern of one woman doctor, four public health nurses, four midwives and four trained dais. Two out of the four beds at the PHC were to be marked for maternity cases, and six beds in a 30 beds hospital were to serve as the referral unit for four PHCs.

In the Fourth Plan (1969-74), a Point Four Programme for the MCH component was adopted by all the states (14). a. Supply of iron and folifer tablets to antenatal mothers and children b. Administration of vitamin A in oil to children between one and six years of age at six monthly intervals, c. immunization against diphtheria, tetanus and whooping cough to be extended to all children in rural areas and d. administration of tetanus to all pregnant mother to prevent tetanus neonatorum. This was redesignated the Point Five Programme in the Fifth plan with the inclusion of immunisation of school children against diphtheria and tetanus (15).



The Minimum Needs Programme (MNP), the scheme for training, Multipurpose Health Auxiliaries, the Community Health Workers (CHW) Scheme and the Dais Training Programme, which were introduced in the Fifth Plan period (or strengthened as in the case of the Dais Training Programme), all aim at providing integrated health, family planning and nutrition services, and extending the coverage of the health delivery system. In 1978, some 32 years after the Bhore Committee report was submitted, the Joint Conference of Central Councils of Health and Family Welfare admitted that Maternal, perinatal, infant and childhood deaths in India continued to be very high and were largely due to lack of preventive factors.

The policy statement of the Janata Government in the late seventies, emphasized the promotion of all aspects of family welfare, and in that context the Joint Conference, adopted the following measures for improving MCH services: a. Screening of mother and children at risk b. Prophylactic immunisation of antenatal mothers with tetanus toxoid, immunization of children with DPT and poliomyelitis vaccines, administration of vitamin A in oil to children, administration of folifer tablets. c. Training of indigenous dais; d. Establishment of referral services for mother and children; e. Quantification of MCH care.

Objectives for PHC and Subcentre level staff: f. Continuing education and refresher training for ANMs to acquaint them with newer approaches to problems. eg. Oral Rehydration Therapy for the management of diarrhoeal diseases and the changes in government policy. g. Adequate supply of essential drugs and diet supplements to health auxiliaries and h. Adequate supervision and support for MCH workers.

MCH and Family Planning MCH services, despite the detailed planning and the expansion of infrastructure and trained personnel, have had little impact on the health of women and children as demonstrated by the continuing high maternal, infant and child mortality and morbidity levels in India. Apart from the problems in implementation highlighted by committees and evaluation studies, the subordination of MCH activities to family planning from 1966 onwards is largely responsible for the poor impact. Instead family planning work being one component of comprehensive MCH services, MCH work became a method of gaining acceptors for family planning.



The pressure on health personnel to fulfill targets is linked to the threat of penalties for nonperformance in family planning. The absence of concrete targets for MCH work resulted in the neglect of MCH activities. According to a recent study, one major reason for nonutilisation of PHC services by the rural population was the association of the latter with the family planning programme. Women preferred the services of traditional dais, as the trained ANM used the postpartum period to complete targets. The under utilisation of immunization camps was due to their being used to gain acceptors among young mothers for copper T insertions. In 1980 the village Health Guide Scheme was transferred from Health to Family Planning. It forms part of the Family Welfare Programme, and is administered by a department primarily interested in fulfilling sterilization targets.

A number of Programmes undertaken by the government have implications for MCH work. These include the Expanded Programme of Immunization (EPI) the Oral Rehydration Therapy programme for control of diarrhoeal diseases, National Programme for the Control of Blindness, Area Development Projects and other components of the Family Planning Programmes and the Integrated Child Development Services (ICDS) Scheme. The delivery of MCH services is made through the primary health centres, family welfare centres and sub-centres in the rural areas, and family welfare centres and postpartum centres in urban areas.

The package of services includes: a. Antenatal, partum and postnatal care: B. Prophylaxis against nutritional anaemia among mothers and children through administration of iron and folic acid supplements c. Prophylaxis against blindness due to Vitamin A deficiency among children (1-5 years) through administration of concentrated vitamin A solution in oil form; d. Expanded Programme of Immunization covering pregnant women e. Health education.

## REFERENCES

1. V.C. Talwalkar 1983 High Maternal Mortality in India, IX Annual Meeting, Medico Friends Circle, Anand (Gujarat) January.
2. UNICEF 1983 Women, Health and Development, A Kit (Geneva: UNICEF)
3. Gopalan C. 1985 'The Mother and Child In India' Economic and Political Weekly, No.4, P.164.
4. S.N. Agarwala 1972 Age at Marriage in India, New Delhi Kitab Mahal 1972 Goyal R.P. 1971 Recent Changes, is Mean Age at Marriage in India 1961-1971.



5. Naik J.P. 1974 and Pradhan Kanala 'Nutritional Problems of women in India some socio economic Aspects' Proceedings of the Nutrition Society of India, Hyderabad No.17.
6. Devaki Jain 1979 Women's Quest for Power: Five Indian Cases, New Delhi.
7. Batliwala Srilatha 1982 Rural Energy Scarcity and Nutrition, A New perspective', Economic and Political Weekly No.9, Feb.27.
8. Government of India 1983 Facts and Figures on Family Welfare, New Delhi Ministry of Health and Family Welfare.
9. Time of India 1984. Cited in V. Balasubrahmanaya, contraception. As If Women Mattered (Bombay: Centre for documentation Education, May 1986) P.36. Chowdhary J.A. 1977 'Morbidity and mortality are to pregnancy and child birth', In WHO Bibliography on Human reproduction, Family Planning and Population Dynamics, New Delhi.
10. Chatterjee M., 1990 Indian Women - Their Health and Economic Productivity - World Bank Discussion Paper 109 p.X.
11. Voluntary Health Association of India (VHAI) Seminar of the national Health Policy: A report, New Delhi VHAI 1983.
12. National Planning Committee, Sub Committee on National Health (Sohkey Committee) Report Bombay 1948.
13. Government of India: Health Survey and Development Committee (BHORE Committee) Report New Delhi 1946.
14. Government of India 1969 Planning Commission, Fourth Five Year Plan 1969-74 (New Delhi: Planning Commission)
15. Government of India 1974 Planning Commission, Fifth Five Year Plan (1974-79) New Delhi: Planning Commission.
16. Government of India 1978 Proceedings of the Fourth Joint Conference of Central Council of Health and Central Family Welfare Council New Delhi Ministry of Health and Family Welfare, Jan.



# PEOPLE'S INVOLVEMENT IN HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN IDENTIFICATION AND PRIORITIZATION OF INTERVENTIONS: SOME ISSUES AND RECOMMENDATIONS

*Dr. Ashok Sahni and Dr. Sudha Xirasagar*

## I. INTRODUCTION

I wish to present before you few basic issues regarding health and development, current processes of identification and prioritisation of interventions, and suggested approaches for effective people's involvement in health and development of women and children.

We have gathered here at the beginning of 1994. In six years time, at the beginning of 2000 AD, India would have a population of approx. 980 million - strong or weak millions. Uncontrolled growth of population, poverty, illiteracy, environmental degradation and health hazards are of major concern to policy makers, administrators, and professionals. In the last two decades, large number of externally assisted projects through World Bank UNFPA, WHO, UNICEF, DANIDA, ODA, USAID, Norwegian Agency for International Development and other agencies have been initiated towards health and development of the people in villages and Urban Slums, particularly women and children. Lately, IMF and World Bank have made aid and loan conditional to demographic management.

Indian Society of Health administrators is committed to health and development of the Country. In the last 14 years, since its formation, it has been engaged in professional manpower development and has trained approx. 40,000 professionals at various levels. It has organized 13 National conferences to influence policy formulation and create professional awareness - two Conferences organized in this very hall- 1987 and 1991. Realizing the importance of people's involvement, we have published two books, viz., *Community Participation in Health and Family Welfare: Innovative Experiences in India* and *The Third Force in Health Care: Voluntary Sector*. We have also produced a film "*Reaching the Unreachable: Role of Voluntary Sector*".

---

*Indian Society of Health Adminstrators,  
15/37, Cambridge Road Cross, Ulsoor,  
Bangalore*



## II HEALTH AND DEVELOPMENT

### PEOPLE'S INVOLVEMENT : ISSUES

1. The goals of health and development have been emphasized in the constitution of India as establishment of a new social order based on equality, freedom, justice and the dignity of the individual. This development is to be achieved through elimination of poverty, ignorance and ill health, by raising the level of nutrition, the standard of living of its people, and the improvement of public health so as to improve the health and strength of workers, men, women, and children and opportunities to develop in a healthy manner. Health is a major pathway to human development and health advances have an instrumental value in the developmental process through their impact on social and economic conditions. Sanitation, housing, nutrition, education, and communications are all important factors contributing to good health by improving the quality of life.

2. Considerable progress has been made in India in all sectors. Keeping in view India's commitment to achieve the Goal of Health For All by 2000 A.D and beyond, innovative approaches to the education and training of medical and health personnel and the re-organization of health services infrastructure were required. What new innovative approaches have been initiated for training of health personnel in primary health care and re-organisation of health services infrastructure?

3. The revised 20-point programme had assigned high priority to the promotion of family planning as a people's programme on voluntary basis and acceleration of welfare programme for women and children, nutrition programmes for pregnant women, nursing mothers and children, especially in the tribal, hilly and backward areas. The health programmes had to be re-organized keeping in view these priorities for women and children. How far these programmes have been re-organized?

4. Health programmes complimentary to the economic programmes will have a synergistic effect on human development. Economic programmes which have a bearing on water, sanitation, housing, roads, and food exert a profound influence on health. How far are these programmes being coordinated and integrated at national, state, district, and block levels?

5. How can there be people's involvement when 83% of the people are ignorant, lack initiative, competency, have inadequate resources and are powerless?



6. In the last three decades many externally assisted projects have been initiated. The major objective of these projects was people's involvement in community development. What has been the impact of these projects on health and development? How far people have been involved in management of these projects?

### **III RECOMMENDATIONS**

1. For effective community involvement, health and development goals for each community need to be established by the community with the assistance of governmental and NGO bodies. For this, health and development profiles or inventories would need to be prepared at local, district, and State levels. These profiles will give us knowledge of the existing situations, gaps, resources and the directions. These are pre-requisites and create a process of community involvement.

2. Health and development depend on improved inter - sectoral collaboration and coordination. This has been emphasized for the last 20 years. For this, appropriate committees at the Centre, State and District levels would need to be formed. Such committees would ensure coordination, mobilization of resources, deployment of resources and formulation of policies and procedures for achievement of development goals.

3. Work and employment are the foremost priorities of our nation's people. All health and family welfare policies and programmes must take this reality as the basis to promote the health and well-being of the people. As recommended by several bodies and the recent Workshop at Ahmedabad organized by ICPD, social security services such as health and family welfare must be closely linked to all efforts for full employment and poverty alleviation.

4. Equality of women and their empowerment (including control over reproductive health), economic, social and political, is essential for the development of our people. How can such equality become a reality?

5. For effective involvement, the community needs to be guided, motivated, trained, supported, informed and educated by the political, administrative, and health care authorities. Whose responsibility is it and how do we implement?

6. For people's health and development, it is essential that the people should be partners in decision-making and should be involved in consultation. For this, we would need to train our administrators and



professional in techniques to involve the community in programmes planning, mobilizing resources, monitoring, and control.

7. One of the major reasons for lack of involvement of the people in health and development programmes is the conflict within the community - mistrust, lack of cooperation, religion, economic and other related factors. Sometimes, created and exploited as part of the political process. We would need to create oneness and bring the community together. This is possible through emergence of leadership in the community. An outstanding example is of Anna Hazare at Relagan Shinde in Maharashtra where every villager is involved in total planning and development. The professionals and administrators would need to identify and develop local leadership of social change.

8. Voluntary organizations would need to be actively involved in community development. The Government of Punjab has provided technical know - how and understanding of the needs of the community to the representatives of the community and voluntary organizations. At the district level, District Coordination Committees with Civil Surgeons as Chairmen and NGO leaders as Vice-Chairmen have been formed. These Committees meet regularly and promote, review, and monitor all activities. Mahila Swasthya Sanghs (MSS) - Local health groups have been formed in all the 13,000 villages and urban slums. Each group has ten members, which means, 1,30,000 grass - root level health workers. This has resulted in a universal coverage of all the weaker and unreached segments of the entire population of the State.

It is recommended that programmes on the lines of Punjab State need to be initiated by every State in the country to ensure people's involvement through voluntary organizations.

9. Since the critical factor in peoples' involvement is leadership, it is essential that leadership is identified, trained, and developed at various levels. Without leadership with commitment for development, there cannot be true peoples' involvement.

10. The 1937 - Bandung Conference had recommended that for effective People's involvement, the health workers must be selected from the community, by the community, and trained in health education and development. Very little has truly been done in this direction. I propose that this IIIrd Regional Conference should reaffirm the recommendations of the 1937 Conference and recommend to the Central and State Governments for effective implementation of this recommendation.



## REFERENCES

1. UPDATE, ICPD Newsletter, November-December, 1993.
2. Freyen, P. et. al. How do Health Workers see Community Participation, World Health Forum, Vol. 14, No.3, 1993.
3. Sahni, Ashok. The Third Force in Health Care: Role of Voluntary Organization in Health and Family Welfare in India. Bangalore; India Society of Health Administrators, 1993.
4. Sahni, Ashok and S.Xirasagar. Community participation in Health and family Welfare: Innovative Experiences in India. Bangalore; Indian Society of Health Administrators, 1990.
5. Development Vs Social Consciousness, Deccan Herald, January 10,1994.



# COMMUNITY HEALTH CARE SYSTEM A MODEL FOR HEALTH IN PANCHAYATI RAJ

*Dr. N.H. Antia*

The existing model for providing health care to the rural population is based on the Primary Health Care concept of the Bhole Committee (1946), reiterated by the WHO at Alma Ata (1978) and by the ICSSR/ICMR report Health For All: An Alternative Strategy (1981). Unfortunately, instead of the envisaged people-based and people-involved system, the existing PHC, the sole vehicle of the government for providing health services to the 70% rural population of India, has become a top down bureaucratic exercise for "delivery" of services. It now has Family Planning as its prime objective. This has distanced it from the people and their health needs. This Community Health Centre (also known as the upgraded PHC or Rural Hospital) has been converted into a mini district hospital of a purely curative nature and not the apex body of all health services for 100,000 population as originally envisaged in the ICSSR/ICMR report.

This has not only created dependency among the people but the coercive Family Planning programme has alienated them from their health services. The single-minded interest in this programme has not only demolished the Health component but has also failed to achieve even the Family Planning "target". The present expenditure on the rural PHC programme is about Rs.27- per capita per annum as compared to about Rs.100/- per capita for the 30% of the population which is urban. There is hence not only need to reallocate resources, but more important, to devise a rural health service in keeping with the epidemiological profile and the people's needs and also involving them in their own health and its care to the largest extent that this is possible. The joint ICSSR/ICMR Committee had analysed the health problems of the country in its widest perspective and had clearly stated that health care is basically the people's own problem. Contrary to common belief health lends itself admirably, technologically, economically as

---

*Dr. N.H. Antia, Director,  
The Foundation for Research in Community Health,  
Thadani Marg.  
84- A, R.G. Bombay, India - 400018*



well as culturally, to a decentralized, small scale, people-based approach. The recommendations of this report have to a considerable extent been reflected in the National Health Policy of 1983.

Several health projects like those described have demonstrated the feasibility of such an approach. With the passing of the Panchayati Raj Bill in Parliament in 1989 for reactivating a decentralized form of government, health will also become a decentralised activity controlled and operated by local bodies from the village Gram Panchayat to the Panchayat Samiti and District levels. This will entail increased inputs at these levels and transfer to the rural health infrastructure and man power to the local bodies, namely the PHCs and the CHCs. It is therefore imperative at this stage to propose a model of health care encompassing the technical, sociological, cultural and economic aspects of this bottom-up approach for a people based health service and its implication on health problems and programmes. The Community Health Care System (CHCSystem) is presented as a model for health services based on Indian experience in decentralised health care. This model proposes to decentralize the health system and services upto the one lakh population level where about 95% to 98% of all health needs - preventive, promotive as well as curative - will be met; about 85% to 90% of this would be eventually undertaken at village and PHC levels.

This model does not depart to any significant extent from the existing rural manpower or infrastructure except for the modest augmentation on a national scale. While the recurring cost of such a health system is envisaged at about Rs.80/- per capita per annum, the major increase will be for non-salary recurring expenditure which at present consist of only 15% of the existing PHC budget. If such a system can demonstrate that the vast majority of health care can be undertaken at this level, including all National Diseases Programmes as well as Family Planning, leaving relatively few cases requiring specialized attention, such increased cost should be justified and acceptable.



**Table 1**  
**Cost of Community Health Care System**  
**(per capita per annum)**

(in Rs.)		
Population level	Health Care Unit	percapita Expenditure
2,500	Village Health Centres	30
20,000	Primary Health Centre	27
1,00,000	Community Health Centres	23
Total	CHC System	80

The cost of such a system, which will provide appropriate health care for most of our country's population which lives in the rural areas, is well within reach but calls for a more balanced distribution of available resources from the current lopsided pattern of expenditure which is biased towards the urban population.

**Table 2**  
**Annual Increases in Health Expenditure**  
**(per capita per annum)**

Expenditure	Rural	Urban
Current*	25	100
Proposed by CHC System	80	100

\* *Broad Estimate*

At present the local private practitioner or the distant district hospital are the chief health resources for the rural population despite the availability of the PHC. The aim of the proposed CHC System is to rectify this anomaly and ensure that "no individual should be unable to secure adequate medical care because of inability to pay for it"; also integration of the preventive, promotive and curative services, making them available as close to the people as possible, in an acceptable manner and within the available resources of the country.



**Table 3**  
**Annual Increase in Health Expenditure**  
**(1990-91)**

(Rs, in crores)

State expenditure	Rural	Urban	Total
Proposed	5,200	4,400	9,600
Current (1990-91)	1,600	4,400	6,000
Increase	3,600		3,600

*Note :* All figures are broad estimates.

In sum we propose to increase the expenditure on rural population to reasonable level while freezing the expenditure on the urban population at the current level. If all the public and private sources of expenditure in the country are included, we find that the country is already spending more than double the proposed expenditure. Besides the 6,000 crores expenditure by the Ministry of Health and Family Welfare, other ministries (Railway, Defence, P & T, etc.) the corporate sector, the municipal bodies, and the ESIS expenditure are in urban areas. If we add to this personal household expenditure, we find that about 6% of the GNP is already being spent on Health. Most of this expenditure is concentrated on the urban population. Our model proposes to reorient this bias. It must be carefully considered whether the mix of the sources of finance should include the Government, Foreign aid, Charity, Insurance - both private, voluntary, public and compulsory or by user charges. This would vary from urban to rural situations.

## **A. AN OVERVIEW OF THE MODEL**

The essence of this model is the Village Health Unit comprising of a full time Community Health Worker and a dai for every 500 population, supported at the 2,500 population (an average Gram Panchayat) level by an Auxiliary Nurse Midwife. Eight such units covering a population of 20,000 (as recommended by the Bhole Committee) being provided supportive services by a PHC. The present PHC covering 30,000 population cannot provide adequate access nor intensive cover to the population. At the 100,000 population level this system envisages a Community Health Centre (CHC). The most important aspect of such a system will be in evolving and operating an entirely different community based system with specific training



reorientation of all health personal for the tasks at each level, also in activating and involving the community in its own health and its care and eventually assumming charge of all the services at the above mentioned levels, through the Panchayati system.

## **REORIENTATION OF PRIORITIES IN THE CHC SYSTEM**

A major cause for the failure to address the health of our people as also of the health system itself is the lack of appreciation of the dominant role of the people in such an intensely personalized human activity. The existing rural public health system has converted health into a technomanagerial bureaucratic exercise dictated from a distant capital where the people are visualised as "targets" for achievement of national goals. On the other hand the private sector, though providing personalized service, has also lost the welfare of the individual and commuunity in its desire to maximise its profits.

The elite, of which the medical profession is a part, has confused education with intelligence and hence feels that the illiterate or even semi-literate poor are incapable of understanding leave aside looking after their own health and welfare. Having secured control of the power and decision making process the elite sections have feathered their own nest utilizing the Western model they seek to imitate. This has inevitably resulted in expensive curative services and hospitals catering primarily to their own requirements in urban enclaves. This has become the first choice not only of the private medical sector but also of the public sector. As a result of the influence that the private sector exerts because of the personalized rapport with the decision makers such as politicians and bureaucrats whom they treat, they are in command of decision making even in the public sector. This has resulted in the diversion of the limited resources of the public sector to urban medical colleges and hospitals where the majority of the private doctors recieve their professional training, based not on the pattern of diseases which affect the majority of our people but on that of the West, (which is also the disease pattern of our elite) for which sophisticated expensive equipment is purchased to train the specialists in medical colleges and hospitals, at public cost. This inversion of priorities, as demonstrated by the distribution of resourses, manpower and health facilities between urban and rural areas, is partly intentional, but is also partly the result of almost total lack of awarness by the medical profession of the medical and health problems that affect the majority of our people, as also the socio-economic and cultural conditions under which the available technology has to be utilized for their benefit.



The Community Health Care Systems aims to correct this imbalance of health priorities where the decision and implementation of most health activities will be from village upwards and not top-down, as at present. Only then can technological and social relevance be brought into the health system. The reality of the cultural and social distance between the medical professionals and the masses has also to be considered in evolving such a system especially at the CHC and PHC levels.

The essence of the model is that the people must not only be actively involved in their own health care but that the health services upto the 100,000 population (Block/Panchayat Samiti) level should be under their administrative as well as financial control and adequate funds should be provided to them for this. Only this can enable people's participation and active involvement as well as ensure accountability into those who are paid to serve them. Without this pre-condition no model can hope to succeed. Much fear has been expressed about the misuse of power at the lower levels but misuse of power and corruption are not the prerogative of any level and are more visible at the lower levels where interpersonal interaction is far easier and misuse can hence be checked.

The dissemination of power to lower levels must be associated with widespread detailed information about all facilities and services and the monetary resources provided for public use. This would prevent monopolizing and diversion of resources to local leaders and lack of accountability by the service personnel. Secrecy is an important mode for avoiding accountability and appropriation of resources.

Panchayati Raj, if implemented in its true spirit of democratic decentralization with delegation of financial and administrative responsibility to the people, will provide this basic requirement as well as the frame work for the implementation of health care at the community level where the majority of the health problems are located. At each level the people have to be provided the resources and power as well as latitude to modify the model to suit their local requirements (eg) to use a mix of the indigenous and allopathic system in the purchase of medicines and supplies and selection of personnel. No targets will be imposed from above but technical information and broad guidelines will be provided for implementation of National Programmes for Disease Control and also for Family Planning.



The responsibility for operation of such a Community Health Care system at each level will be vested in the people and their Panchayati institutions. The panchayat bodies, especially at the Gram panchayat level, will be supported by people's Committees. These bodies will be free to consult their health personnel or any other source to facilitate decision making and functioning. The health functionaries will report at each level to the respective panchayat body and the people. The technical planning of the Community Health Care System will be undertaken by the panchayats in consultation with the available technical personnel at the PHC and CHC. The disbursement of salaries and other expenditures will be through the panchayats and the ratio of salaries to supplies at all levels will be in a ratio of 60:40 and not 85:15 as at present. The maximum expenditure will be at the village level, with the per capita expenditure, declining at higher levels. Power will not be vested only in the elected members of the panchayat but will be shared by representative people's Committees which will function with the health workers and the Gram panchayats. The majority of the members of the people's Committees should be women, as will also be the health workers of this village system.

This Community Health Care model does not provide rigid directives but only broad guidelines. The ratio of population to personnel is flexible at each level and can be modified to local circumstances. However, there will be no transfers of staff, so inimical to continuity of operation and for purpose of building rapport and ensuring accountability. Inefficient staff may be warned or dismissed by the panchayat bodies, but not imposed on another panchayat through transfers. Not being government staff the problems of unions will not arise.

Since the majority of the population consists of women and children and most of the health problems affect them, all health workers at the village level must be women who will live and work as an integral part of the community which will pay their salary and to which alone they will be finally accountable. They will work towards a common purposeful goal collaborating not only between themselves but also with the Anganwadi (ICDS) worker and the teachers of the village school. They will receive support from the PHC and CHC, both of which will also be under the control of the community through the Gram panchayats and panchayat samiti, and the people's Committees at each level.



**Table 4**  
**Community Health Care System**

Population level	Panchayat Unit	Health Unit	Estimated Percentage Care
2,500 (Gram Panchayat)		VILLAGE HEALTH UNIT	80
500	"	1 Village Health Worker (Female)	
500	"	1 Dai (Female)	
2,500	"	1 Multi - purpose worker (Female)	
20,000 Group of GPs		PRIMARY HEALTH CENTRE	13
		2 Doctors 3 Nurses 10 beds	
		staffing pattern as for present PHC	
Panchayat Samiti		COMMUNITY HEALTH CENTRE	5
100,000 Block		Senior Medical Officer (PSM)	
		<div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;">           (Preventive)            1 PSM doctor            4 Health Assistants            1 statistician         </div> <div style="text-align: center;">           (Curative)            Rural Hospital            60-100 beds +            dharmashala,            with 5 basic specialists            and 4 General Practitioners         </div> </div>	
1 million	(District)	District Hospital	1.75
5 million	(City)	Tertiary Care Hospital	0.25

Each of the levels of the CHC System are components of a single comprehensive people's health unit, for only when all levels function in concert can the CHC System be truly effective. Should any one of the units be isolated, the entire system will be dysfunctional. We have seen this happen to the present day Community Health Workers, PHCs and Community Health Centres (Rural Hospitals).



## **REFERRAL SYSTEM**

A graded referral service is a key element of the CHC system. Each level will refer cases to the next level and there will be no by-passing of lower levels to reach the hospital directly. The adequate services at the village level and the PHC attached to the CHC should ensure that the Rural Hospital is utilized only as a referral centre as per actual medical and Public Health requirements. The Community Health Care System is based on 'Functional Classification of Diseases' which is used as the basis for setting priorities and grading the levels of health care.

## **FUNCTIONAL CLASSIFICATION OF DISEASES**

Classification of diseases is necessary for diagnosis as well as treatment. While diagnosis must theoretically precede treatment, in the majority of cases when the patient first presents her/himself, treatment is chiefly on a symptomatic basis after eliminating any serious condition posing an immediate threat to life or limb. Else the diagnosis is self-evident and can be treated on the basis of simple clinical examination.

This approach is not only cost-effective, in time as well as expense for both the patient as well as the doctor, but it also avoids unnecessary investigation. What most patients need at this stage is assurance and information, as to when and how to seek additional advice and/or treatment, in the unlikely event of this being a prodromal symptom or sign of a more significant disease. In actual practice waiting and watching is one of the most important tools in the medical armamentarium.

The degree of confidence with which an ailment can and should be diagnosed or managed depends not only on the skill of the physician but also on the disease itself. It also depends on the individual and national resources, which may be the predominant factor in countries where the overall health manpower and public as well as personnel resources are limited or scarce. This constraint also operates among the poor sections in affluent countries where health services in the public sector are restricted. Even in a country like Britain, with a tradition of good health care in the public sector which is available to all its citizens, the burgeoning cost of health care necessitates, that the utilization of available medical manpower and resources be optimized. This has been achieved by encouraging self-care and the use of paramedics and nurses for help in the home as well as in hospitals, and relieving the load on the more expensive doctor and specialist services. Expensive investigations and services are also rationed.



Such an appropriately graded form of health care is not only cost-effective, but is generally more acceptable to the patient, as it is more readily available and permits intimate interaction and caring which is so often lost in the increasingly technology oriented medicine. While desirable in a country like Britain there is no alternative to such a graded system in a country like India, if health care is to reach the majority of our people who are dispersed in the 600,000 villages. The proliferation of allopathic doctors from 59,338 to over 3,00,000 since 1947 has failed to solve the problem of the control of communicable diseases which are still responsible for the major mortality and morbidity load of our people. Instead we have a plethora of public and private medical practitioners and specialists in the cities and towns, while 70% of the population who live in rural areas do not have access to even the most elementary form of health care. The current medical education, which tries to imitate the latest technological trends of the West, is steeped in the diagnostic approach, based on pathology. In actual practice, as a result of the absence of even elementary facilities for investigation in most situations, a dangerous blunderbuss type of symptomatic medicine is actually the rule.

It is hence necessary to evolve a more functional classification where diseases are classified not according to their pathology but according to the varying levels of skills and facilities needed for their diagnosis, management and care. Experience in health care projects such as our own at Mandwa has demonstrated the advantages of differentiating diseases by utilizing a more practical and functional approach. In this approach diseases are classified not according to pathology but more according to the knowledge, skills and facilities required for their diagnosis, treatment, prevention and control.

Broadly speaking diseases can be grouped in the following five categories:

*Category A:* A PHC study by the National Institute of Mental Health and Neurosciences revealed that 25% of all attendance at a PHC comprises of psychosomatic problems which need understanding and explanation rather than a pill or injection.

*Category B:* These comprise of simple, self-limiting diseases which can be adequately handled by the individual and the family itself; eg. minor coughs, colds, diarrhoeas, bodyaches, headaches, cuts, bruises, boils, minor allergies and a host of everyday conditions. Both the diagnostic as well as the treatment skills are a part of most families and the community and are managed by utilizing home and folk



remedies and/or some cheap and safe over-the counter drug like aspirin.

*Category C:* These are diseases which are not life threatening but are nevertheless responsible for a substantial part of the community's morbidity load, such as scabies, worms, moderately severe diarrhoea, dysentery, acute tracheo-bronchitis, moderately severe cuts, bruises, abdominal colic, osteoarthritis, chronic dermatosis, common fevers, chronic obstructive pulmonary disease.

They can be adequately diagnosed and looked after by properly trained paramedical workers with a modest repertoire of safe but effective drugs, and even more important, by advice for management such as ORT, steam inhalation or how to apply sulphur ointment or benzyl benzoate. Such advice would be even more appropriate for their prevention than those of the doctor, because of the physical and cultural proximity of these workers to the people, as well as the low cost of such an approach.

*Category D:* This category comprises of diseases like severe gastroenteritis and dysentery, acute respiratory tract infection, tuberculosis, tetanus, leprosy, malaria, poliomyelitis, measles, pneumonitis, rheumatic heart disease and sexually transmitted diseases. They are the major killers and maimers in the tropics today despite the fact that we have effective knowledge as well as means for their prevention, treatment and control. The knowledge and technology for this is remarkably simple, cheap and effective, as well as safe. Yet the medical profession has revealed its inability to control these diseases despite monopolizing health care services. Experiments such as at Mandwa, Banaswari and Jamkhed have revealed that even these diseases can be most effectively tackled by the people themselves in conjunction with their paramedical workers. The problem therefore lies not in the inadequacy of medical science and technology or their availability, but in the inability to reach these to the people through the over-professionalized and over bureaucratized health system in both the public as well as the private sectors. Four decades of experience under the prevailing conditions dictates that this can only be attained through the community's own efforts closely supported by community based paramedical workers, who in turn, must be taught and supported by the medical profession and the health services. Withholding this simple and readily available knowledge and technology merely because of the dangerous consequences of these diseases (especially if not diagnosed and treated in the early stages) and a few untoward reactions to drugs, has proved counter-productive.



Many of these diseases can be prevented by attending to nutrition, environment, water and sanitation, besides the immunization of the high risk groups within the community. Even diseases like tuberculosis and leprosy can be readily suspected by trained community health workers and paramedics and referred to the doctor for confirmation of diagnosis. The prescribed treatment regimen can then be given and supervised by the local workers, and the patient referred back for occasional check-up or if any of the well-known complications of the disease or untoward effects of treatment should arise. Others, especially in situations where medical help is unavailable, can be treated by trained community workers with short courses of drugs like chloroquine, enteroquinone, sulphonamides, metronidazole, aminophylline or oral penicillin and can be referred only if the seriousness of the condition so warrants. The role of the medical profession must be of a guiding, encouraging and supportive and not of an appropriative nature. Professionals, however highly trained, have clearly demonstrated their inability to achieve the desired results using the latter approach at vastly greater expense. It is often difficult for the professional to understand this, in view of the impersonalized, curative nature of present day medical education and practice.

*Category E:* Comprises of those high profile but relatively few conditions which need skill and facilities that can only be provided by the medical profession and the hospital. These include major medical and surgical problems and emergencies which are beyond the scope of the paramedical worker, who can nevertheless be taught to provide adequate first aid before referral, as well as follow-up and after care. Early diagnoses by such workers, as for cancer, tuberculosis and leprosy, can greatly reduce the load and expense for the treatment of advanced disease so often seen in our hospitals, besides being far more humane as far as the patient is concerned.

It is realized that in a few cases in each category the severity of the disease may increase and upgrade it to the next higher category or categories. A holding period of 48 or 72 hours is generally indicated, following which persistence or exaggeration of symptoms indicate referral to the next level of care. The paramedical workers can be taught the signs and symptoms of a few diseases/problems like meningitis and abdominal pain or injury where immediate referral is necessary when in doubt.



## THE RATIONALE FOR THIS CLASSIFICATION

Such a classification may seem to smack of over simplification and even dangerous practice to those who work in countries where quality medical services are readily available to all. Yet a similar attitude by the medical profession in countries where even elementary medical services are inaccessible to most has been extremely counter-productive because it denies available medical knowledge and technology to the majority of the people. This approach also leaves relatively few problems requiring greater knowledge, skills and facilities for the medical profession. They can then devote much more of their time as well as the limited expensive resources for secondary and tertiary care for which they are specifically trained. The risk of not utilizing the available knowledge and technology far outweighs the danger of withholding it, certainly under the prevailing circumstances, and even when the socio-economic conditions improve.

The present approach has only succeeded in mystifying health and medical care and placing it within reach only of the affluent minority who can afford to pay for services or, through influence, monopolize whatever effective services are provided by the public sector. The medical professionals, who increasingly perceive medicine as a lucrative business, have also mesmerized themselves into believing that "West is Best". They have alienated themselves from the masses as well as from their socio-economic problems and culture. The result is that they firmly believe that there is no alternative to the present system, despite it proving to be increasingly counter-productive. The pharmaceutical and medical instrumentation industry, whose sole motive is profit, has spared no effort in reinforcing the belief among the professionals and the public that modern health care must follow the latest Western pattern, however expensive and inappropriate it may prove even in the countries of their origin.

## AN ALTERNATIVE APPROACH

The alternative model, as proposed in the ICSSR/ICMR report "Health for All - An Alternative Strategy", envisaged that the vast majority of all preventive, promotive and curative health care would be undertaken by and within the *Gram Panchayat* and *Panchayat Samiti*, at one lakh level. It was based on the principle that health lends itself both technically and culturally to be operated most cost-effectively in a decentralized system as conceived for the Panchayati Raj. This is possible provided the health and illness approaches are graded and operated according to the skills and facilities, as indicated by the categories described above.



Such an approach would involve the people in their own health care and help release them from the clutches of the health industry. It would also establish the rapport and confidence between the people and their most important first level contact, the paramedical workers, without whom no programme can succeed. This will require the provision of more knowledge and availability of essential drugs with the community health and paramedical workers. This approach will have to be modified to suit the prevailing epidemiological and social realities which vary from urban to rural areas, from region to region, and often from village to village, in a vast and varied country like India.

## **B. LEVELS OF HEALTH CARE IN THE CHC SYSTEM**

The CHC System will utilize existing staff to the extent possible and retrain them specifically for their entirely new functions as compared to that of the existing Community Health Workers (CHWs). Auxiliary Nurse Midwife (ANM), doctors and nurses. It may be necessary to give new designations in the local language, to these almost entirely different functionaries to distinguish them from their older counterparts.

### **THE FIRST LEVEL : THE VILLAGE HEALTH UNIT**

The village health unit will comprise of a female multi-purpose worker for every 2,500 population, living in a central village, with five "new" CHWs and five "new" dais, one for 500 population. They will function as a single unit under the Gram Panchayat/s and its bodies like women's and Youth Organizations. The population criterion is not rigid and should be modified to suit local accessibility, just as the number of workers may be modified to suit local needs. Here, only the minimum requirements are specified.

All workers at this level must be females. Eight such "Village Units" will be supported by a PHC consisting of doctors, nurses, paramedics, out-patients units and about 10 beds. The aim will be to see that the Village Health Unit and PHC work as a single coordinated unit responsive and accountable to the community; not to the hierarchical health structure.

The present PHC has one subcentre at 5000 population level staffed by one male and one female multi-purpose worker (MPW). There also exists one part-time CHW paid an honorarium of Rs. 50 per every 1000 population. They are supported by Dais (Trained Birth Assistants).



Since the major work-load for all health functions is to be conducted at this level in the proposed system, and as almost 90% of all functions involve women and children, a substantial increase in the female staff at this level is essential. The annual per capita expenditure will be about Rs.30/- at this level.

**Table 5**  
**Village Health Unit**  
**(2,500 Population)**

No.of Workers	Designation	Monthly Salary Rs.	Annual Expenditure Rs.
1.	Multi - purpose Worker Female (ANM)	2,000 (Existing Govt, Salary)	24,000
5.	Community Health Workers (Female)	300 (on par with Anganwadi worker)	18,000
5.	Dais (Female)	50 (per delivery)	3,750 (estimated)
Total Salary			45,750
Other recurring expenditure (Supplies, medicines, transport, etc.)			30,000
Total Expenditure			Rs. 75,750
Per. Capita			Rs. 30/-

*Ratio of salaries to other expenditure is 60 : 40.*

No male workers will be employed as almost all functions can be best conducted by female staff working as a single unit. The majority of the male MPW's functions can also be carried out by the ANMs and CHWs with the help of the community, eg. water, sanitation, insecticide spraying. These are community functions. Experience also reveals the poor functioning of male workers as compared to ANMs and female CHWs. This will also help to intensify coverage by the ANM to the Gram Panchayat 2,500 level without increased cost.



## FEMALE MULTI-PURPOSE WORKER (THE NEW ANM)

The present ANM at the 5000 population (subcentre) level, despite all her problems, lack of training, motivation and trasferability, is still the most useful memembr of the PHC team. As a female she can develop rapport with the women and children, can understand or sympathize with them, even though the FP target pressures alienate her from the community. She is unfortunately trained in a distant hospital type setting which has little to do with her actual field duties. Her main role in the existing PHC set-up is to ensure the fulfilment of the quota given for achieving FP targets, often in conflict with the other workers. This obsession with FP targets has runied what can be a most useful resource not only for health but also for Family planning. The present approach has alienated her from the younger females who would come for non-terminal methods and Medical Termination of Pregnancy (MTP) if provided discreetly and with sensitivity.

This new functionary will be almost entirely different from the traditional ANM by training, motivation and the functions assigned to her. She will be primarily a community asset like the CHW and will stay and work with the 5 CHWs and dais in the 2500 population covered by her, as the leader of the village health team. She will be primarily accountable to the community who will pay for her services. She will be a resident of the community and not liable to transfer. This will not only increase her credibility and effectiveness but prevent the harassment the present ANM has to suffer at the hands of PHC as well as the community and its leader as a young female from outside the village community.

She will be recruited from the local commuity if she has passed the SSC level and has the motivation and desire for the work and to serve her community. Preference will be given to a CHW if she fulfils these requirements. If such a person is not available trained ANMs can be recruited and subjected to rigorous retraining for their new duties. A new recruit will need 24 months training while the ANM will require about 6months of reorientation.

The training will be provided at the PHC level and be highly specific for the multiple health requirements at this level, but not for hospital type duties. She will be trained in the local languages, as a teacher and supporter of her team of CHWs and dais, and will provide the first level reference service for them. Whenever possible she will encourage the CHWs and dais to undertake responsibility and work



and not try to appropriate their functions. Emphasis in her training will be to look after Maternal and Child Health (MCH) activities, including delivery of uncomplicated primipara, and to be able to screen problems prior to referral transfer to the PHC. Also to provide emergency care during the period of transfer to the referral unit. The training will include preventive medicine, health education, basic epidemiology, treatment and control for all national disease programmes, and to provide adequate contraceptive technology to those who seek it. Also to provide the health inputs into anganwadis and schools in her area. Since Maternity and Child Health will be her priority and special interest, all deliveries will be conducted by her at the subcentre referring only the high risk cases to the PHC. This will help to institutionalize deliveries so important for reduction of maternal mortality and morbidity.

She will in turn receive support and in - service training from the PHC staff who will visit her on a regular basis and in turn obtain a report of the health status of the community. Her monthly visit to the PHC will be an occasion for education, communication with the PHC staff and other ANMs of the area and exchange of information; not for reporting on FP targets or collection of salary and supplies as at present. She will be the key paramedical worker in the whole health system.

The job specifications of this ANM will hence be as follows:

- a) Train and support the 5 CHWs and dais to work as a team for preventive, promotive and curative activities.
- b) To undertake all national programmes to the extent possible at the village level.
- c) Monitor all health activities in the 2,500 population assigned to her.
- d) Organize and operate the subcentre as a first level referral centre including a bed for deliveries and emergencies.
- e) Compile records of the CHWs, analyze for local use and forward to the PHC.
- f) School health education and health component of anganwadis.
- g) Liaise with PHC, provide monthly reports and refer cases needing such care.
- h) Health education and information for the community, its leaders and various groups and submit monthly report of activities.



- i) Daily visit to one CHW - tasks include immunization, help maintaining records of high risk cases, etc.
- j) Arrange for purchases / availability of drugs and supplies for the subcentre and their distribution to the CHWs and accounting for proper use.

## COMMUNITY HEALTH WORKER (CHW)

Since a substantive, if not majority, of the health functions of the village will be carried out by the people themselves with their own CHWs, it is proposed to have one CHW for every 500 population if adequate health coverage is to be achieved. Since this will occupy the majority of their time and they will also be available on call any time of the day and night, and adequate emolument equivalent atleast to the anganwadi worker will be required. This will also provide over a million useful employment opportunities to women within the community itself, an important consideration. Being a local resident she will have intimate knowledge of each member of the 100 households she serves. Hers will be as much a social as a technical function.

Numerous experiments in training and utilizing of village women as CHWs have revealed that a remarkably large number of health and illness functions are technically feasible for being undertaken by such workers provided they are appropriately trained and also supported by the community and the health services and made accountable to the community. Also that even semi-literate women have a capacity to absorb the knowledge and utilize the technology if made available to them in a simple manner and in a language that they can understand.

The CHW will be selected by her community with motivation being the most important criterion. Not merely the elected leaders but all local groups, especially the Mahila Mandals, will be involved in this selection.

The community will be informed of all her duties. She will have to provide a detailed written as well as verbal report every month to the community at large (not merely the sarpanch) especially to the Mahila Mandal and Gram Sabha. Only after their approval will the salary be disbursed to her by the Gram Panchayat. She will work in collaboration with the other CHWs of her village, the dai as also the ANM. The latter will both teach and support her. The CHW will also provide health inputs into the Anganwadi and school in collaboration with her supporting ANM.



Her accountability will be to the community and not to the PHC, though the latter will provide her with necessary information, training and referral support via the ANM. The 5 CHW's, dais, and the ANM at the 2500 level will work as a single co-ordinated team for all health functions at this level, including training, information exchange about local health problems and support in emergencies. Her training and support will be mainly by her ANM, and chiefly as continuous in-service education; not a one shot affair at a distant centre, as at present. Training manuals, list of duties, drugs, epidemiological approach, disease care, referral, emergency measures, etc., will be part of such training. The guidance and support of the ANM will be accessible at all times but weekly or possibly more frequent visits of the ANM to her and her community will be assured. Record keeping will be simplified and used locally for self-monitoring and use, eg. ANC, PNC, high risk case, immunization. A system of simple but meaningful recording will have to be evolved. Above all there will be no transfers or targets. The services of a non-performing CHW may be terminated by the community by common consent.

CHW'S duties will be:

- a) Keeping simple but necessary records of each household and especially high risk cases.
- b) Formal and informal health education and information to the individuals and groups.
- c) Ensure proper sanitation, water supply and management of general environment.
- d) Ensure implementation of all national health programmes utilizing the support of her ANM and through her, of the PHC.
- e) Undertake curative services to the extent possible and maintain stocks of drugs and supplies.
- f) Early detection of diseases like leprosy, TB, Malaria, gastroenteritis, etc., have the diagnosis confirmed and ensure compliance to the prescribed treatment.
- g) To warn the community of epidemics and help in mobilizing them for their control.
- h) Ensure rapport with eligible couples and offer contraceptive advice and services.



- i) Work with the ANM and the other members of the village unit as part of an integrated team.
- i) Report to the ANM the Gram Panchayat and the various groups in her area.

The CHWs will be trained by the ANM of their village unit.

### **Trained Birth assistant (Dai)**

The job requirements of the Dai would be:

- a) To support the CHW in MCH activities.
- b) Act as a health educator.
- c) Assist the CHW as and when required.

She will be a traditional birth attendant of the community and will work with the village team of CHW and ANM. While actual deliveries will be conducted by the ANM, the dai will help in early reporting of pregnancy, help in ANC and PNC, using her close rapport with the community. She will be paid Rs. 50/-per delivery for fulfilling these tasks.

## **THE SECOND LEVEL : THE PRIMARY HEALTH CENTRE**

The primary Health Centre should serve as the first back-up for the village health unit. There will be one Primary Health Centre for 20,000 population. The reason for keeping to the 20,000 rather than the 30,000 population as for the existing PHCs, is because there is considerable evidence that utilization of services depends on the proximity to the first level referral care, viz. PHC. The Bhole Committee in 1946 had also recommended, 20,000 population coverage for each PHC. If in this new System 90% or more of all the health activities have to be conducted within the PHC level, there is no reason why more intensive inputs should not be available at this level. This will also increase the intensity of care per population.



**Table 6**  
**Primary Health Centre (20,000 population)**  
**(Proposed Expenditure)**

No.of Workers	Head of Expenditure	Monthly Salary	Annual Expenditure
2	Doctors	5,000	1.20,000
2	Nurses	2,500	60,000
2	Health Assistants (Senior MPWs)	2,000	48,000
1	Lab cum X-ray Technician	1, 500	18,000
1	Store Keeper cum Statistical Clerk	1,500	18,000
4	Helpers	1,000	48,000
1	Driver	1,000	12,000
Total Salaries		27,000	3.24.000
Other Recurring Expenditure (Supplies, Medicine, Transport,etc.)		18,000	2,16,000
Total Expenditure		45,000	5.40,000
Per Capita		Rs. 2.25	Rs.27.00

Ratio of salaries to other recurring expenditure = 60:40.

Ten beds will be available for in-patient care.



At about Rs.27/-Per capita annually, the major services Provided by the PHC will be :

- 1) Out-Patient care chiefly of a first referral nature. To avoid overload with minor problems of the locality. the local village health unit i.e. CHW + ANM, will be placed adjacent to the PHC to attend to such problems.
- 2) In-patient services-medical, minor surgery, sterilization operations.
- 3) Delivery of moderate risk cases needing episiotomy or use of low forceps.
- 4) Epidemiological monitoring and prevention and control of epidemics.
- 5) First aid and referral for services requiring hospital facilities.

The PHC will have the normal complement of two MBBS doctors, one preferably female. There may be one additional doctor trained in the indigenous systems of medicine who will promote these systems and offer them to the patients and the community. The choice of treatment will eventually be left to patients and appropriate herbal and homeopathic remedies should also be promoted. This integrated approach to all systems will be an important part of this new approach. It may also be worth considering whether an entirely new functionary should be trained for this level, such as a B.Sc. in Rural Health, who will be specifically trained to take charge of the PHC. Considering the reluctance of doctors to work in rural PHCs their inappropriate training and entirely different requirements for the PHC, this alternative should be given serious consideration to provide adequately trained and motivated leadership to the PHC staff and the entire team.

## **MEDICAL OFFICERS AT THE PHC**

The duties of the Medical Officers will be:

- 1) To oversee the smooth functioning of the PHC in all its aspects, as stated in the PHC manual.
- 2) To co-ordinate the activities of all health workers in the area.
- 3) To maintain close liaison with the community at all levels and help them to understand and participate in this new approach.
- 4) To train and support all the staff at the PHC, the MPW s and the ANMs and through them the ANMs, CHWS AND DAIS.



- 5) To monitor the health of the community by collating all data and taking suitable corrective measures especially in the case of epidemics.
- 6) To ensure proper implementation of all the National Programmes including Family Planning through regular functioning of the paramedical staff; not through targets or camps which disturb routine activity.
- 7) To provide supportive referral services for all cases needing care which can be made available at the PHC level, inclusive of medical and surgical emergencies, sterilization operations etc, and to keep a record for eventual analysis.
- 8) To provide first aid to major emergencies and ensure safe transfer to the CHC (Rural Hospital).
- 9) To ensure close contact with the CHC, which is the next level of the CHC System, for preventive, promotive as well as curative service and provide them with necessary statistical or other information as required.
- 10) To organize and supervise the pathology services, drugs and other supplies and transport service at the PHC.
- 11) To regularly visit the peripheral workers to help solve their difficulties, teach them in the field, and provide necessary support and help. Gross deficiencies in staff and supplies etc, which affect the community's health must be reported and discussed with the community and help them to take the necessary corrective and/or disciplinary action.
- 12) To maintain liaison with the community at large and its various official and non-official bodies.

## **TRAINED NURSE (NM)**

The PHC will have three fully trained nurses who will provide nursing support, supervision of ANMs, care of indoor and outdoor patients and supervise and help in the operation theatre, deliveries requiring forceps, episiotomy, I.V. drip, etc.

A major function will be to devise a training programme and provide support to the 8 ANMs who will form the backbone of this decentralized Community Health Care System.



### THIRD LEVEL OF HEALTH CARE

#### THE COMMUNITY HEALTH CENTRE

The CHC of the ICSSR/ICMR report was designed as the co-ordinating centre for all health activities of the population to which it has to provide the necessary support. The emphasis was on the preventive and promotive services based on the social, cultural and epidemiological reality of the area. Hence the Principal Medical Officer (PMO) in charge should preferably be an individual with post-graduate training in preventive and Social Medicine (PSM). Even if a Medical Officer from another discipline occupies this crucial post he would have to undergo additional training in PSM for at least six months with special orientation in the social, cultural and political factors which play a dominant role in the proper functioning of the health services of the area. While the curative specialist services, because of their very nature, would require the largest infrastructural facilities, human-power and financial requirements of the CHC, the PSM aspect would nevertheless play the dominant role in health as opposed to the important though secondary role of the higher profile curative services. Unfortunately the CHCs (called Rural Hospitals or upgraded PHCs in some States) designed on the basis of the recommendations of the ICSSR/ICMR report have been converted into purely curative hospitals isolated from the public health services and under the Civil Surgeon of the District who also serves in a purely curative role. Picked out of context from the holistic approach of this report these Community Health Centres (Rural Hospitals) have not only failed to appreciate the community health concept but despite substantial inputs have failed even to provide adequate curative services due to the isolation from the community. They have also failed to attract the necessary specialist staff of doctors and nurses. Like the Community health Workers' concept it has been implemented out of context and hence caused another major setback to an otherwise sound concept for rural health care.

The location of the CHC, like the PHC, cannot be left to the whims of the local politician for garnering votes. This is important not only for providing easy access to those it serves but also for the availability of basic facilities like regular electricity, water supply, drainage and communication, which are not only essential for the functioning of the PHC but also to attract the city trained medical and nursing professionals who desire for such facilities not only for themselves but also for their families. With increasing urbanization even the small taluka



townships now provide such facilities. One of the major difficulties of city bred personnel (doctors and nurses) working in rural areas is the intellectual isolation and absence of suitable schools for their children. Even China could not wish this away. The provision of these facilities to the extent possible must be given high priority.

## **THE PUBLIC HEALTH COMPONENT**

This is the key function of the CHC for co-ordinating all health activities from the village and PHC to the CHC. The PSM trained Principal Medical Officer in charge has hence to be the senior-most medical officer in charge of the CHC and should be responsible for smooth functioning of both the Public Health as well as the curative services. He has to have his own staff for monitoring the preventive and promotive health of the entire community and keeping the Panchayat Samiti and Gram Panchayats informed and involved not only of routine activities and National Programmes but also to take necessary action to prevent the outbreak or control of epidemics. This is an epidemiological and sociological function requiring constant outdoor activity in the community and contact with the PHC and village staff and the community at all levels. Diffusion of relevant health education and information to the grassroots, continuous training of all health personnel, ensuring adequate availability of drugs and supplies, communication and transport, especially for emergencies, solving interpersonal problems between the health staff and also between them and the community. These are some of the important functions of this key component of the system. Also maintenance of vital statistics and overseeing of all national programmes not only at every level but also for communicating and co-ordinating at the district level. The difficulty lies not at the technical level for which the incumbent is trained, but at the social level for which s/he is neither culturally attuned nor provided adequate training or guidance. As a consequence the easiest path to align with the local leadership which hardly represents the community at large and, more often than not, places its own interest above that of the rest. Hence the PMO has to reach out and understand the problems of the silent majority, a far more difficult and arduous task. In this his/her contact with the Village Health Units is crucial. No office bound PMO will ever be able to meet such commitments. The role is to provide support, monitor all activities and ensure smooth functioning, not supervising or policing in the normal bureaucratic manner. The absence of transfers and targets should greatly help in this. Adequate transport and fuel must be available to provide mobility to this PSM team, a jeep and motorcycles.



## THE CURATIVE COMPONENT

This is an important part of the Community Health Care System which cannot gain the community's confidence unless their felt need for curative services, especially in emergencies, is met for most of their problems. An efficient Rural Hospital as part of the CHC System is therefore essential.

Its functions consist of:

- a) Providing back-up for all curative problems that are beyond the skills and facilities at the PHC.
- b) Providing a high level of specialized medical and surgical care for most referral problems of the community and within its easy reach, leaving very few problems requiring greater skills and facilities for the District or Tertiary level hospitals.
- c) Maintaining close liaison with the PHC by regular visits of specialists to provide consultancy advice to the MO at the PHC, select cases requiring admission to the Rural Hospital and provide follow-up of such patients as near their home as possible. This should also provide continuous in-service education and intellectual stimulation to the isolated staff of the PHC.
- d) To provide a high level of emergency care to the community at any time of the day or night.

In order to fulfil these functions the Rural Hospital is designed as a well-staffed and adequately equipped 60 bedded hospital capable of being extended to serve 100 to 150 patients with an attached dharmashala for those who do not require acute hospital beds but only need medical supervision. The five broad-based specialists consisting of physician, surgeon, gynaecologist, paediatrician and anaesthetist have to be provided an adequate supportive staff of fully-trained doctors, nurses paramedicals, technicians for pathology and X-ray as also ANMs and a large number of staff recruited from the local community. Staff quarters must be provided to those who do not come from the local community. The basic investigative services such as X-ray and pathology, must be available to meet all but super-speciality requirements as also a good transport service for routine as well as emergency use. The staff must be trained in maintenance and routine service and repairs of all equipment, with spares for essential components. The operation theatre should have equipment for all basic surgical and gynaecological operations as well as additional equipment for common



aspects of super speciality treatment like trephine for head injuries and a knife for skin grafting which can be best undertaken at this level with some additional training and facilities. Almost 50% to 80% of most super-speciality work can be best undertaken at this level provided the broad-based specialists are adequately trained and provided the supportive services.

**Table 7**  
**Community Health Centre (1,00,000 population)**  
**(Proposed Expenditure)**

No.of Workers	Head of Expenditure	Monthly Salary	Annual Expenditure
1	Principal M.O	6,500	78,000
*5	Specialists	6,000	3,54,000
4	General practitioners	5,000	2,40,000
4	Nurses	2,500	1,20,000
8	ANMs	2,000	1,92,000
1	X-ray Technician	2,000	24,000
1	Path Technician	2,000	24,000
1	Store Keeper	1,500	18,000
1	Statistician	2,000	24,000
2	Drivers	1,500	36,000
12	Helpers (including Administrative Staff)	1,000	1,44,000
4	Health Assistants	2,500	1,20,000
Total Salaries		1,14,500	13,74,000
** Other Recurring Expenditure (Supplies Medicines, Transport, etc)		76,333	9,15,996
Total Expenditure		1,90,833	22,89,996
Per Capita			Rs.22.89

\* Surgeon, physician, gynaecologist, paediatrician and anaesthetist.  
\*\* Ratio of salaries to other recurring expenditure = 60:40



With the staff to recurring expenditure ratio at 60:40, the average expenditure of the rural hospital would be approximately Rs.23 lakhs per annum or Rs.23/- per capita.

Such a Community Health Care System should be able to monitor and support almost 95% to 98% of all preventive, promotive and curative services for the community it serves. In order that the CHC does not get swamped with routine PHC type of work-load of the local population, one of the PHCs will be sited within the CHC campus to screen the local population and only entertain cases referred by the PHCs.

A small institution of this nature with its intimate relationship with the community would provide job satisfaction which cannot be achieved in the frustratingly large, impersonal and bureaucratized urban hospitals. The local community in charge of this Health System with its political influence, can help in overcoming financial and logistic problems influence, as this will be in their own interest. Since there cannot be duplication of the staff in such a small unit and because of absence of super-specialization there will be sharing of duties and responsibilities to cover all eventualities.

Liaison will be maintained with the nearest District and City Hospital for referral problems as well as for continuous updating of technology.

In order to maintain the academic and social morale of the staff and their dependents, adequate facilities must be provided for transport of children to schools, recreation, good library facilities, etc. In remote areas where the CHC cannot be located in a taluka town, additional facilities will have to be provided to this nucleus of about 15 families to overcome the physical and mental isolation. Unless this human aspect of the personnel is considered no amount of expenditure on building and equipment can serve the purpose. The community will not only ensure accountability but also provide support.

The quality of leadership of the CHC system will be the most crucial factor, which will include not only technical but also managerial and cultural skills.



## **TECHNICAL REQUIREMENTS**

1. Knowledge of communicable diseases.
2. Knowledge of diseases of women and children.
3. Knowledge of epidemiology.
4. Knowledge of dealing with emergencies - medical and surgical - first aid, transport, definitive care.
5. Knowledge of dealing with epidemics.
6. Knowledge of preventive and social medicine.
7. Knowledge of health education and communication.
8. Ability for self-education.
9. Knowledge of what to refer for tertiary care and broad knowledge of functioning of the entire CHC system.
10. Knowledge of statistics and its use.
11. Organization and use as well as limitations of local available pathology and diagnostic facilities e.g. sputum, microscopy, X-ray, etc.

## **MANAGERIAL REQUIREMENTS**

Training in basic managerial skills, manpower building and equipment, transport, stores, supplies, accountancy, rules, regulations, discipline, etc., and legal aspects.

## **CULTURAL REQUIREMENTS**

1. Adjusting to the local culture.
2. Empathy for the under-privileged who most require such services.
3. Training in aspects of social sciences:
  - a) Social and individual behaviour
  - b) Dynamics of village life and its politics
  - c) Causes of socio-economic disparity
  - d) Caste, class and creed



4. Awareness of difference between education, literacy and intelligence.
5. Understanding of village, taluka and district administration and politics and how to deal with these.
6. Understanding the culture of other workers eg. MPW, ANM, CHW, dai.

## **C: LOGISTIC REQUIREMENTS FOR THE CHC SYSTEM LABORATORY AND X-RAY SERVICES**

A diploma trained pathology technician to undertake pathology investigations. Study of the pathology load, quantity, quality and type of investigation and the cost needs to be undertaken within this system. The doctors can also be taught to operate the X-ray machine at the PHC and CHC level.

## **DRUGS**

A detailed study of the type and quantity of drug requirements, mode of purchase, distribution and utilization, cost and maintaining records and accounts at each level will be an important aspect of this approach. Direct purchase from the market will be taught to the community (under medical prescription) as also how to obtain drugs from the government for national programmes like immunization, tuberculosis and leprosy.

The feasibility or otherwise of cost recovery through drugs and pathology tests may be studied, provided this does not eliminate health care for those who cannot pay for services.

The use of drugs should be strictly rational and under generic names as far as possible. An important outcome of research will be a better understanding of the drug requirements and cost at each level of the PHC and village units.

## **RECORDS**

Detailed records have to be maintained not only for use of the CHC system but for use by the system as well as by the community. Family records will be maintained by the CHW. Recording should be simplified and designed chiefly for local usage at each level as also for onward transmission.



## **TRANSPORT**

Bicycles and motorcycles will be used wherever possible and jeep-ambulance will be available for transport of staff and patients. Adequate transport for good health care in rural areas is essential. Telecommunication would help in the case of emergencies and maintaining contact with all village staff as well as continuous information and education.

It is envisaged that the three levels of health care of the CHC system should be able to take care of almost all the health needs at one lakh population level, leaving only a few cases needing specialized care for the District Hospital and Tertiary Care Hospitals.

## **D. OPERATION OF MAJOR HEALTH PROGRAMMES IN THE CHC SYSTEM**

The following illustrate the modus operandi for some of the major health programmes of the country in this system.

### **VERTICAL PROGRAMMES**

Every discipline dealing with one disease or one problem feels that the highest priority be given to it, eg. family planning, malaria, blindness, leprosy, etc. This has led to an increasing number of vertical programmes with competing interests, which are often at cross purposes with each other and often in conflict. Some programmes like leprosy and malaria have their own line of authority and though the staff may be posted under the PHC they are accountable to their own service superiors. The salary scales are also variable. This has resulted in multiple responsibilities and multiple control of personnel leading to lack of co-ordination and accountability as well as indiscipline even within the PHC staff, leave aside to the community. Those disciplines with greater resources like Family Planning, Immunization, Malaria and Leprosy get priority over other equal or even more important programmes like Tuberculosis. The programmes for rehabilitation receive very low priority. This has also led to a fragmented approach with the emphasis shifting with priorities dictated from above. The prevalence of diseases in a vast country vary from region to region, taluka to taluka and often from village to village. While vertical programmes may be convenient from the bureaucratic and administrative angle they cannot relate to the local reality, prevent realistic assessment of the local problems and involvement of the community in planning and implementation. The community cannot see its prob-



lems in such a fragmented manner. Community involvement can only be achieved if health activities start with their perceived priorities - eg. curative medicine and maternity services - and then proceed to preventive and promotive aspects. Once rapport and confidence are established between the people and their health personnel and they see the advantage of the latter the task becomes easier.

The aim of this model is to have an integrated approach to all programmes which would not only be cost effective but would achieve better results in each programme because of the crucial input of community involvement. Workers will be trained in the basic aspects in all programmes and as to how the community can be involved, because it affects their welfare and not that of a distant authority. The real felt need of the community for curative and emergency services and child birth facilities will receive its due emphasis which will help in gaining credibility and community support even for the other programmes.

The Mandwa project illustrated the advantages of this horizontal strategy especially at the village level, besides being far more cost-effective. The village cannot differentiate between separate health programmes and activities nor can it differentiate between health and all other activities such as school education and anganwadis in its own village, leave aside its various economic activities, since they are all part of the normal village functioning. Integrated approach to the various social and economic programmes is part and parcel of the village functioning which cannot see any of these in isolation. Integration is therefore inherent in most village activities though it poses major if not insuperable problems in vertical programmes. This, despite constant appeal for intra-and inter-sectoral co-operation and co-ordination which seldom succeeds. This is a major advantage and strength of decentralized people-based village programmes and activities. We will not examine how some major National Health Programmes can be operationalised in this CHC System.

## **FAMILY PLANNING (FP)**

The present 'target' approach for FP utilizing the PHC infrastructure is now realized as unsuccessful by everyone, including the Government, as it has failed to achieve the desired result. The growth rate has remained at about 2% for the past three decades. In the process it has adversely affected the health services and alienated the



people from the PHC and all its other programmes and functioning. The role of health in Family planning is chiefly in making available contraceptive technology in a highly confidential and acceptable manner for people who see the need and desire it. It is increasingly realized that the crude propaganda and coercive sterilization 'camp' approach is counter-productive and that FP should be conducted as a routine village and PHC activity without disturbing other programmes and curative services. Far more important is to increase the acceptance of non-terminal methods by the younger age group. These groups and especially the female are anxious to utilize non-terminal methods including Medical Termination of Pregnancy (MTP) rather than undergo illegal abortion with all its dangers and expense. This can be achieved only if the ANM and CHW can reestablish the rapport with these individuals through personal contact, avoid target pressures and deliver all other aspects of curative services required of them. The approach must be individual, personalized and highly confidential with follow-up services as and when required. IUDs cannot be accepted because of extensive prevalence of genital tract infection and this may need special attention. The male partner also needs to be contacted and FP must be a part of the entire MCH services and not in reverse. STDs, including AIDS, will also be part of this programme requiring confidentiality. There must be genuine concern for the welfare of the people rather than a mere Family Welfare designation for the population control strategy. Sex education in schools and non-formal channels is an important but neglected area and can be most effectively conducted by the Village Health team of ANM and CHWs.

## **MALARIA**

The resurgence of malaria despite massive inputs into this vertical programme indicates the need for a new strategy. Basically the malaria worker has to visit villages and individual households, ask for anyone with fever with rigors, take a blood smear and administer tablets of chloroquine. If the smear is positive definitive treatment has to be given with primaquine. If there are a number of cases in the village locality spraying of the households has to be undertaken. The rare case with complications, generally the result of neglected early detection and treatment, is referred to the PHC doctor.

A major handicap of the vertically operated programme is the inability to visit each household regularly, contact the senior household person and ensure that the staff undertake their duties regularly. Leave vacancies and transfers also interfere with maintenance of continuity



and regularity. It is evident that the technical skills for this programme are simple but what is required is regularity and constant availability. The CHW can fulfil both these functions and also warn the community of an impending epidemic. Since the CHW and villagers are the persons who suffer from malaria and its consequences, it is in their interest not only to detect but also spray the household, using the same equipment they use for spraying insecticide in the fields. The CHW who knows every household personally can receive information on a daily basis, take a smear and have it examined at the PHC.

The village has therefore an in-built interest as well as the necessary human power, drugs and equipment for control of this national disease at far lower cost. The only additional skill lies in the examination and early reporting of smears which can be performed at the PHC by the pathology technician who will now be responsible to the community, and support from the PHC for the occasional difficult or unusual problem.

## **TUBERCULOSIS AND LEPROSY**

The experience of domiciliary treatment of tuberculosis demonstrates that the CHWs have the ability to suspect early cases using the classical signs and symptoms especially when they occur in close proximity to the index case. After referring them to the doctor for sputum examination and confirmation of diagnosis they can ensure regularity of the prescribed treatment through their intimate relationship with the patient, family and community. The few complications of the disease or its treatment can be referred back to the PHC doctor. Measures for preventing spread can also be ensured by creating awareness in both patients and the community. This also applies to leprosy.

Several NGO experiences have revealed that most of the major national programmes can be most effectively controlled at the village level by local workers given training, encouragement and adequate supportive service. This is far more effective and cheaper than vertical programmes "delivered" to the people by external agencies.

## **MATERNITY SERVICES**

Early detection of pregnancy can also be undertaken at the village level by the CHW and dai who can undertake routine ANC care with the help of the ANM. High risk pregnancies can be referred to PHC for advice. In such a system all deliveries can be institutionalized and



conducted by the ANM at her subcenter where a bed can be available for this purpose. The ANM must receive special attention to the problems of child birth in her training. Very high risk cases which may need high forceps or Cæsarian section will be referred by the PHC to the CHC. ANC and PNC service can also be undertaken by the same village team including immunization, care of the infant and Family Planning advice. The expected load will be about 15 deliveries per year at the CHW level and 75 at the ANM level i.e. about one delivery every 5 days.

## **INFORMATION, EDUCATION AND COMMUNICATION (IEC)**

This is the key to community involvement and will be undertaken in three ways:

*1. Health Education :* This will consist of information about the problems of health and its maintenance. Also about diseases, their cause, Transmission, prevention, control and treatment at each level and the role of the people and of each worker; the necessity for regularity in the treatment of chronic ailments, the dangers of unnecessary and dangerous medications, use of various systems of medicine and their strengths and weaknesses, demystification, first aid, cost of drugs, their mode of action, reactions and the natural course of diseases.

### *2. Health Information :*

- a) It is essential to inform the public about the availability of both public and private medical and health services from the villages to the PHC,CHC, district and urban hospital
- b) Provide information about the role of the functionaries as to how the community can support them as well as demand their services.
- c) To warn about malpractice at all levels, its avoidance and action against it, both in the public as well as the private sector.
- d) Information about the cost of proper health services and care.
- e) Provide information about the people's own role in their health and how they can undertake this with the support of their own workers,



*3. Communication:* Most projects have clearly demonstrated the dominant role of word of mouth in village communications, where a village health worker (CHW), convinced of subject like the germ theory by looking down a microscope, can transmit the knowledge to the entire village in her constant non-formal interaction. This has proved far superior to inputs by highly trained communicators and other external media which can only act as supportive aids. The most important aspect is to redefine the functions of the CHW and provide her proper information to enable her to use her natural communicating skills to the best advantage. The ANM, in her training, must also be provided the skills for communication which is virtually non-existent in her present curriculum.

The audience should comprise of the entire village community through individual, group, school and existing formal and non-formal channels. The communication will have to be tailored differently for the gram panchayat leaders or mahila mandals, children and adolescents in schools and illiterate adults.

Schools will receive special attention where the ANM will not only impart education on health but also encourage school health check-up where students, teachers CHWs and ANMs will do preliminary screening leaving only a few cases for the medical officer.

Posters, audio-visuals, etc., will also be used as supplementary methods especially at weekly bazaars, fairs and other community functions

The key to the Community Health Care System is IEC, not as per the textbook but by much more informal techniques. It is essential to integrate into any IEC programme information on other aspects of community life and development programmes which are of equal or greater interest to the people.

The involvement of the Medical Staff in devising better education programmes and in the evaluation of the impact will add to the importance and credibility of the IEC and in the process sensitize them to the importance of education and information in achieving health goals.

IEC Cannot succeed unless there is close human rapport and mutual respect between the educators and the audience. In actual practise it is more in the nature of a discussion, often under a tree in the village or the verandah of a school or gram panchayat, where



technical health information is exchanged and discussed with the practical wisdom of the villagers and their health workers. Only thus can the special problems of each village and 'basti' (locality) be understood and solutions evolved.

## REHABILITATION

The ability of the community to accept both the mentally and physically disabled needs to be established. Though medical science may offer aids to rehabilitation, it generally entails taking the patient to special urban centres often for prolonged periods. These centres often do not appreciate the problems encountered by the rural disabled because of their predominantly urban orientation, eg. living at floor level, conditions of rural roads, lack of servicing and replacement facilities for aids and appliances. Many simple rehabilitation techniques have been devised for rural areas and can be taught to the family/individual via the CHW-eg. prevention of contracture by daily mobilization of joints. The prolonged separation of the disabled from the community due to distant rehabilitation centres also results in their rejection by those who otherwise accept them as part of the family and community. This is especially true in diseases like leprosy and mental illness.

While each village has its small load of the mental and physically disabled, collecting them in mental hospitals or homes not only converts them into a major and expensive problem but lack of funding, and motivated sensitive staff often reduces them to conditions far worse than in their village setting.

## OTHER SPECIAL PROGRAMMES

Dental and oral hygiene, blindness, cancer, heart, hypertension, stroke (including rheumatic fever), sanitation, water management, respiratory tract infections, genital tract infections- STD, leucorrhea, AIDS-can also be undertaken more effectively through such a system of decentralized health care.

The 'Camp' approach is highly undesirable whether for sterilization operations or for other disease like leprosy, blindness or general check-up. This high profile approach interferes with all routine low profile work and serves little more than a charity-oriented approach by service organizations. It disorganizes the health system and often is an apology for devising an adequate health care system. Restricted to curative services, often in the periphery of cities, it hooks the poor on



to unnecessary, expensive drugs and injections like tonics, vitamins and antibiotics supplied by the pharmaceutical industry to the doctors 'free' of cost. This approach also creates a feeling of dependency on charity doled out to the poor without any impact on the overall health problems, many of which are of a non-medical and social nature. The poor do not need charity for health care which is their right.

## **TRAINING IN THE CHC SYSTEM**

Although the designation and duration of training of the personnel may remain the same they will have to function in an entirely different manner in this system, both technically as well as socially. There will be no 'special' programmes like Family Planning with their associated 'target'. All aspects of health will have to receive their due attention and they will no more be accountable to a hierarchical bureaucracy but to the community. They will also have to function as an integrated team with support rather than supervision as the mode. Supervision and support will be by the community, who will also have to be trained for these functions.

The main features of the training of all cadres will be:

1. Social and community orientation.
2. Team concept.
3. Emphasis on health education and provision of information.
4. Demystification and involvement of the community in its health activities to the extent possible.
5. Emphasis on epidemiological approach and preventive health.
6. Highly practical training, as far as possible in the field, for solving local problems under prevailing conditions.
7. Continuous rather than one-shot training.
8. Maintenance and utilization of data for service as well as research.
9. Training for implementation of all National Programmes under such a decentralized community based approach.

The fully trained nurses- Nurse Midwives (NMs)-can play a crucial role in training of the ANMs who will be the key functionary of the Village Unit. The functional classification of diseases' will serve as a useful guide for devising and providing a new dimension to the training.



The success of this new health care system will, to a considerable extent, depend on the retraining and reorientation of the present personnel like doctors, nurses and ANMs. This will be conducted initially locally at the PHC and subcentres. Later this will become an ongoing activity in the field and village. Joint sessions will be conducted with the community to develop necessary rapport and exchange of information and discussing problems. Continuous training, monitoring and support by the next level of functionaries must be given the highest priority, eg. the ANM, who will be trained and supported by the NM, will in turn be taught to be the trainer, mentor and supporter of the 5 CHWs and dais working under her. This will be preferable to the Medical Officers training every level of workers like the CHW and dai at the PHC or CHC, not only because of the unwidely nature of such exercise but because of the cultural and language distance between these functionaries and also because knowledge of the actual problems lies in the village and field.

## **E. RELEVANCE OF THE CHC MODEL**

This model is based on the assumption that it may serve as a model for use on a country-wide scale. Hence the PHC and CHC infrastructure of this model does not deviate to any significant extent from the existing governmental set-up. The cost of such a CHC System serving about 100,000 population will be at about Rs. 80/-per capita per annum and should be acceptable under the enhanced rural health inputs as envisaged under the Panchayati Raj System, especially if it greatly reduces the load and expenditure on the far more expensive urban hospital and referral service. The present public expenditure on health is about Rs. 100/-per capita in the urban area and Rs. 27/-per capita for the rural area.

The demonstration a more efficient cost-benefit system which delivers effective health care within the community itself will generate a demand for re-allocation of health resources to the community, especially if this is within the available national resources for health. The useful employment generated for over a million village women will itself be a social and political incentive for implementation of such a system.

It is presumed that the community which has enjoyed the benefits of good health care at its doorstep will be sufficiently activated to ensure its continuation by :



- a) Demand for and better utilization of available public health services as well as of private service at all levels.
- b) Demand for increased inputs at the community level.
- c) Raise local resources for additional inputs by :

i) User charges of a graded nature of services such as pathology, ANC and supply of drugs. These charges will be much lower than incurred in the private sector and will ensure better service. Those who cannot afford to pay must also be ensured of the same service.

ii) Insurance for health- these should be explored after the actual requirements have been established.

Feasibility of the model will also depend on the following factors :

1) Whether a far more effective health care system can be provided by this model at a reasonable increase in cost.

2) Since it is a local community based model it will operate optimally where the community is organized ( not only for health but all its other social and economic activities) and hence most suitable for the forthcoming Panchayati Raj. Panchayati Raj, without the availability of such a detailed community based model, would only result in the continued propagation of the existing top- down health model by both the health services as well as by the community, who do not know of any alternative. This would negate the advantages that could accrue to them if a truly community based model of the type envisaged could be employed.

3) Since this model does not depart to any great extent from the existing PHC structure and is well within the existing expenditure of the health system as a whole (and well below what is being spent in the urban system) there should be no great financial difficulty in its widespread application. The most significant change will be in the mode of operation and not its structure or expense.

4) A major requirement will have to be change in the attitude and approach of both the health personnel as well as of the community. The promotive and preventive aspects of health will have to be emphasized together with demystification of the curative component, especially among the community. The major change will have to be in attitude rather than in medical technology. This is bound to be a much slower process and a part of education for Panchayati Raj as a whole.



5) The usage of this system will be governed to a great extent by the education level of the population and especially of the female. Also on the extent of political awareness of the community, as demonstrated in Kerala.

## **F. THE DIFFERENCE BETWEEN THE PRESENT AND THE PROPOSED SYSTEM**

The best should not be the enemy of the good. The CHC system is not a second rate system for the poor but is a technically, economically and culturally sound model for providing appropriate health care to the vast majority of our population, especially those who continue to live in rural India. Although it utilizes almost the same infrastructure as the existing system, the two are entirely different in approach. Some important differences in the present and the new system are as follows:

<b>PRESENT SYSTEM</b>	<b>NEW SYSTEM</b>
Top-down service	Bottom-up service
Bureaucratic	Non-bureaucratic
No involvement of people	People chiefly involved
Lack of accountability to people	Accountable to people
Secretive and mystified	Demystified
Service oriented	People oriented
Vertical programme oriented	Horizontal, involving all programmes
Poor accessibility & availability	Excellent accessibility & availability
Staff to other expenses ratio 85:15	Staff to other expenses 60:40
Percentage of total health care very low	Percentage of total health care high
Cost benefit ratio : low	Cost benefit ratio : high
Emphasis on static PHC Unit and doctor	Emphasis on mobile units Within the village
Centralized	Decentralized
Target-oriented	Problem-oriented, with emphasis on preventive and promotive aspects of health.



## COMMUNITY ORGANIZATION

This will be the single-most important aspect of this model as the whole concept of the community Health Care System is based on the community being involved and eventually taking responsibility for its own health care including the health services meant for their welfare. One of the greatest difficulties in involving the community is the unfortunate image that has been inculcated into it since Independence. Health has been increasingly mystified and an impression created that this is chiefly the purview of trained health professionals and that too of doctors. The indigenous systems, including traditional folk remedies, have been down-graded and good health care has been equated with allopathic doctors, hospitals, patent medicines and injections. This is clearly demonstrated because even the poorest villager has now been hooked on to injections and weaned away from self-care. The positive aspects of health which are a part of our traditional practices are being lost and replaced by this new type of illness care, much of which is illogical, often dangerous and profit-oriented. An ICMR study in Halgaon district demonstrated this clearly and showed how the meagre resources of the poorest are being diverted from food to medicines and that too of the wrong type.

Despite the lack of accountability and functional failure of the public sector and the exploitative nature of the private sector a climate has been engendered among the people for such medical services, together with a simultaneous attitude of abject dependency on such services. Mystification and fear combined with quick relief by misuse of potent drugs has undermined their inherent ability to solve their own health problems, as in the past.

This is demonstrated even in a State like West Bengal where the Panchayats are willing to take responsibility in all sectors except health. On the other hand in Kerala, which does not have the Panchayat System, the available services of the PHC and Mini-centres are well-utilized and even demanded as a result of public education and information. The unnecessary utilization of drugs such as antibiotics in the private sector is also questioned as a result of the science education provided by KSSP. There is also ample evidence from various projects that given information, education and encouragement the community has not only the capacity to overcome such inculcated dependency but also to demand and better utilize the available services.



A major, if not the most important, aspect of this approach is to study in detail the cause of this dependency in health (as also in other fields) and to explore methods by which the community as a whole (not merely through its VHVs) can accept responsibility for all aspects of their health, and eventually to take both administrative and financial responsibility. This will require strong sociological inputs into understanding the perceptions of the community about its health and health problems as well as of the public and private health services. Suitable methods must be devised for self-help.

Without a strong community involvement the model will only become another exercise in a modification of the existing topdown "delivery" system used not only by the government but also by many NGOs. It is hoped that such a community based health care system as envisaged by the ICSSR/ICMR report will eventually serve as a model in the forthcoming Panchayati Raj, contrary to the present "dependency" creating public and private service.

## **G. ADVANTAGES AND DISADVANTAGES OF THE CHC SYSTEM**

The major advantages of the Community Health Care System are

- 1) Epidemiological, not clinical approach.
- 2) Technically, economically and culturally sound.
- 3) Comprehensive care, appropriately graded.
- 4) Almost 98% of all care within the 1 lakh population.
- 5) Financial and administrative control with people, hence accountability built into the system.
- 6) Emphasis on the social and non-medical aspects of health.
- 7) Demystification of health which is primarily the people's own function.
- 8) Physical and social accessibility of health services to all.
- 9) Simplification and transfer of technology and its availability to the people at the village level.
- 10) Enhanced knowledge and participation by people in the majority of their health functions.
- 11) No targets and no transfers.



12) Cost-effective.

13) Major avenue for providing useful employment and enhancing the status of rural women.

14) Reduces load on high cost urban hospital services, both in numbers as well as advanced disease resulting from late detection and neglect at the primary stages.

The major handicaps of Community Health Care System may be summed up as follow :

1. Needs political will for effective two tier Panchayati Raj.
2. Risk of mismanagement and local misuse.
3. Needs extensive public information.
4. Needs specific job-oriented training.
5. Slower though surer process.
6. Observed as a threat by the professionals and the health industry.

## **H. ROLE OF THE STATE IN THE CHC SYSTEM**

The role of the State is to see that the basic health facilities are available to all regardless of their ability to pay and to ensure that nobody goes without the basic requirements for health. There should be adequate resources for infrastructure and staff as well as appropriate training of manpower at all levels. The role of the State is to redistribute resources for this purpose and ensure that they are adequately utilized through the Panchayat System.

Redistribution would have to be within the public sector in the urban and rural infrastructure but the State must also monitor the private sector for the quality of health care and their accountability to the public. A well-informed public given an efficient public health service will provide the most effective countervailing influence on the private sector. Privatization of the public services will mean an abrogation by the government of its responsibility to the people and especially the poor, who will be deprived of health care as they will be unable to pay for private services except under duress.



## **I. AREAS WHICH REQUIRE RESEARCH**

The following are some of the crucial areas which should be studied during the initial stages of the operation of this model:

1. People's participation in the health system.
2. Accessibility and accountability of the PHC to the people.
3. Social and cultural factors influencing health behaviour.
4. Traditional health practices and practitioners.
5. Impact of health education and information.
6. Usage frequency of the services, both public and private.
7. Impact on health status of the community.
8. Details of the morbidity patterns.
9. Logistics-requirements of drugs, supplies, transport, etc.
10. Costing.
11. Training requirements.
12. Recommendations for the health service on the basis of the model, in various aspects like medical education, drug policy, etc.

## **J. BROADER IMPLICATIONS OF THE MODEL**

If the model is operated nationwide, it will have far-reaching implications on several health related issues like health manpower planning, medical education, training of supportive non-medical personnel, selection and evaluation of technology, production of drugs and instruments, status of non-allopathic systems in the health structure and appropriate medical research.

It will encourage widespread experimentation in designing alternative systems possibly in collaboration with NGOs. This will require more sociological, economic and technological inputs at higher levels of decision making, rather than leaving it entirely to non-medical administrators. Other sectors, particularly sanitation, water supply, infrastructure and education will have to be simultaneously improved on similar lines. The CHC System is set within a decentralized framework and operationalizing the model ultimately implies decentralization to the extent possible in all areas.



In the ultimate, the operation of the health system will be determined by the political will either to look after the basic needs of all, as decided at Independence, or exaggerated needs of a few. In a democracy it is for the people to ultimately decide what is in their best interest. They can do this only if they are provided appropriate and correct information.

## FOR FURTHER READING

1. AIDAN and VHAI. A Rational Drug Policy: Problems, Perspectives, Recommendations. New Delhi. VHAI.1986.
2. Antia N.H and Batliwala S. Determining Manpower Needs, Theme Paper VI for FRCH/ICSSR Workshop on Health Care. Bombay. FRCH. 1977.
3. Ashtekar Sham. Village Level Health Care : Problems and Possibilities. Bombay. Medico Friends Circle. 1990.
4. Balasubramanian A.V. and Vaidya Radhika M. Local Health Traditions: An Introduction. LSPSS Monograph No.1 Madras. Lok Swasthya Parampara Samvardhan Samiti. 1989.
5. Benerji Debabar. Social and Cultural Foundations of the Health Services Systems of India. New Delhi. Centre of Social Medicine and Community Health. Jawaharlal Nehru University.
6. Benerji Debabar. Western Medicine in Developing Countries: The Case of India. New Delhi. Centre of Social Medicine and Community Health, Jawaharlal Nehru University. 1984.
7. Batliwala Srilatha. The Historical Development of Health Services in India. Bombay. FRCH. 1978.
8. Bhatt Ela (Ed.). Convergence of Social Welfare Services Related to Mother and Child Care. Paper presented at workshop on 'Convergence of Social Welfare Services'. Bombay. FRCH. 1990.
9. Desai Vasant. Panchayati Raj - Power to the People. Bombay. Himalaya Publication House. 1990.
10. Draft Report of the Task Force Constituted to Examine in Detail the village Health Guide Scheme. New Delhi. GOI. Undated.
11. Duggal Ravi. A Review of the Bhore Committee, 1946 and its Relavance, 1990. FRCH Newsletter Vol. IV Nos. 1-2, Jan-Apr. 1990. Pages 3-17.
12. Duggal Ravi and Jesani Amar. Health Care Services in India: Facts Revealing Gross Maldistribution. (Paper Presented to the Planning Commission, GOI). Bombay. FRCH. 1990.



# SURVEY OF MOTHERS ON THEIR ATTITUDES AND SOURCES OF INFORMATION ON INFANT FEEDING PRACTICES

*Lt. Col. P.B. Pillai.*

## INTRODUCTION

One of the three principle causes of morbidity, mortality and retarded growth and development amongst children in developing countries is early infant malnutrition (1). In recent years, scientific evidence has persistently demonstrated that although breast feeding may not be in itself be a solution to all the problems of infant survival, it still represents an invaluable resource in its prevention (2). The practice of breast feeding in western countries, though declined in the course of this century, the trend started reversing by 1970's (3). In India, though the breast feeding is still popular amongst majority of mothers, there is an identifiable decline in the prevalence and duration of breast feeding amongst certain segments of population, and in particular in urban areas (4). A joint WHO/UNICEF meeting on infant and young child feeding has reproached this poor infant feeding practices as a bolt on our so called development. These agencies voiced their concern and advised to improve infant feeding practices and breast feeding where ever it declined and to take action to reinforce and protect current trend where it has not declined (5).

The infant has no choice and is totally dependent on its mother for its nourishment. Thus, it is the attitude of the mother about breast feeding that generally determines the infant feeding practices she is likely to adopt. Here I made an effort to find out the attitudes of mothers towards infant feeding practices at an Armed Forces Hospital as the population has an all India character with an ultimate aim of trying to find the reasons for visible decline in breast feeding habits in our country.

---

*Lt. Col. P.B. Pillai.*

*Reader, Dept of P.S.M*

*Armed forces medical college, Pune - 411040*



## **MATERIALS AND METHODS**

The present study was carried out at the Family Welfare Centre (FWC) located in the campus of military hospital, Secunderabad. The centre carries out well baby clinic on every Friday and Saturday. The FWC educates mothers on infant feeding practices, prevention of communicable diseases, and family planning practices and carries out immunisation. 100% registration of mothers is carried out, resulting in universal immunisation of all the children. All administrative support is provided to the mothers to attend the well baby clinic. This study was carried out during the period from Sep. '88 to Dec '88. The attitudes of the mother were elicited by interview using a pretested questionnaire. All the mothers who have a surviving infant (up to 12 months of age) reporting to FWC for any purpose during the study period were selected for the study.

## **RESULTS**

### **CHARACTERISTICS OF THE POPULATION STUDIED**

Majority of the mothers interviewed were mainly from the families of armed forces personnel with a small percentage from civilian population (Table -1). Majority of the mothers were wives of NCOs followed by that of sepoy. The study population generally resembled the national population in their religion, mother tongue and urban / rural residence (Tables 2,3 & 5). 80% of fathers and 50% of mothers were educated upto and above secondary level (Table-4). Majority of mothers interviewed were aged below 30 years (table - 6) and had their deliveries in hospital (Table -7)

### **MOTHERS ATTITUDE TOWARDS INFANT FEEDING PRACTICES**

All the mothers were unanimous that breast feeding is essential for the good health of the baby. Majority of the mothers felt that the breast feeding should start with in 24 hrs of delivery (Table - 8). 68% of the mothers felt that feeding the baby with colostrum was good for the baby (Table - 9). 87% of mothers expressed the view that the infant should be breast fed for more than 12 months (Table-10). 64.0% felt that introduction of supplementary foods (liquids and/or solids) should be considered before the age of 8 months (table -11). 74% of mothers believed that they should eat more food than normal during the period of lactation (Table-9). The commonest sources of information for



mothers on infant feeding practices were mainly the close relatives followed by the health Personnel (Table -12). Only 10% of the mothers state that they were influenced by the mass media like TV, Radio, News paper etc.

## DISCUSSION

Breast feeding is one of the best sources of nutrition for the first one year of postnatal life. In the last one decade international bodies have been highly concerned with the high infant mortality rate. They all have uniformly acceded that to achieve health for all by the year 2000 AD, infant health is one of the most important factors needing high priority.

Though a large number of studies have been carried out in India to find out knowledge, attitudes and practices of breast feeding, most of such studies have a common drawback that they pertain to specific geographical localities in the country (6).

Hence in the present study an attempt was made to obtain information from the families of the Armed Forces of India, which represent most of the different ethnic/cultural groups of the country.

In the present study 50% of the mothers were educated up to secondary level and above. 85% of the deliveries were institutional. The economic status of the population, other than officers, is generally comparable to lower middle class of India society. The provision of health care and delivery system is comparable to developed countries. Thus we have a population which generally represents India in this ethnic characters and at the same time had the characteristics of developed countries in its educational and health care delivery systems.

The main source of information to mothers regarding infant feeding practices were the close relatives, like mother, mother-in-law, grand parents, and health workers like hospital staff and the staff of FWC. This study gives an impression that economic development and improvement in education status of women need not wean them away from good and time tested infant feeding practices existing in our country, provided health care delivery systems are properly oriented towards preventive and promotive aspects rather than concentrating on super specialised curative aspects, as is done in the Armed forces of our country.



Thus our traditional society can be an asset despite all the "development" in the fields of economics, education, social status etc. provided the health workers are well oriented for proper mix.

## REFERENCES

1. Strengthening ministries for primary health care. Offset Publication no.82, World Health Organisation, Geneva,1984.
2. Jellife D B, and Jellife E F P. Human in the modern world - Psychosocial, Nutritional and Economic significance: Oxford University press, Oxford, New York.
3. Methodology for determination of breast feeding patterns. Maternal and child health. World Health Organisation, Geneva, 1981.
4. South East Asia regional workshop for the promotion of breast feeding, Sri Lanka, 23 -24 April 1981, World Health Organisation, Geneva.
5. A joint WHO/UNICEF meeting on infant and young child feeding, Geneva 9 -10 Oct 1979, World Health Organisation, Geneva, 1979.
6. Contemporary patterns of breast feeding, Report on WHO collaborative study on breast feeding, World Health Organisation, Geneva, 1981.
7. Gopujkar P V, Shaudhury S N, Ramaswamy M A, Gore M S, Gopalan C. Infant feeding practices with special reference to the use of commercial infant foods. Nutrition foundation of India, Scientific report number 4.1981.

**TABLE 1**  
**Distribution of THE HUSBANDS by their RANK**

Rank	n	Percentage
Officers	34	9.88
JCOs	6	1.74
NCOs	175	50.87
Sepoys	108	31.40
Civilians	21	6.10
Total	344	100.00



**TABLE 2**  
**Distribution of mothers by RELIGION**

Religion	n	Percentage of	
		sample	India *
Hindu	291	84.59	82.65
Muslim	8	2.33	11.35
Christian	22	6.40	2.33
Sikh	19	5.52	1.96
Others	4	1.16	1.61
Total	344	100.00	100.00

*\*Source Manorama year book 1988 page 387*

**TABLE 3**  
**Distribution of mothers by their MOTHER TONGUE**

Mother tongue	n	Percentage
Hindi	122	35.47
Telugu	55	15.99
Bengali	18	5.23
Marathi	26	7.56
Tamil	36	10.47
Malayalam	20	5.81
Punjabi	24	6.98
Oriya	10	2.91
Others	33	9.59
Total	344	100.00



**TABLE 4****Distribution of wife and husband by their URBAN/RURAL STATUS**

Father	Mother		Total
	Rural	Urban	
Rural	233	36	269 (78.20)
Urban	12	63	75 (21.80)
Total	245(71.22)	99(28.78)	344 (100)

*Note: Numbers in parenthesis are percentage*

**TABLE 5****Distribution of wife and husband by their EDUCATION**

Father's education	Mother's education			Total
	Middle & Below	Secondary	College & above	
Middle & below	55	14	1	70(20.35)
Secondary	82	36	10	128(37.21)
College & above	40	30	76	146(42.44)
Total	177(51.45)	80(23.26)	87(25.29)	344(100)

*Note: Numbers in parenthesis are percentages*



**TABLE 6**

**Distribution of mothers by their age and parity of the present baby.**

Age of mother (in years)	Parity				Total	Cumulative %
	I	II	III	IV & above		
<= 20	8	3	-	-	11	3.20
20-24	83	49	16	3	151	47.09
25-29	30	52	42	13	137	86.90
30-34	5	5	18	7	35	97.09
= > 35	-	1	-	5	6	98.84
Total	126	110	76	28	340	100.00

**TABLE 7**

**Distribution of mothers by  
PLACE and MODE of delivery of the last baby**

Place of delivery	Mode of delivery		Total
	Normal	LSCS or Forceps	
Home	52	--	52 (15.16)
Hospital	252	39	291 (84.84)
Total	304 (88.63)	39 (11.37)	343 (100)

*Note: Numbers in parenthesis are percentages*



**TABLE 8**

**Distribution of present infant as per the TIME of INITIATION  
of breast feeding after birth**

Time (in hours) breast feed initiated	n	Percentage
=< 24 hrs	206	59.88
24-48	59	17.15
> = 48 hrs	72	20.93
Never breast fed	7	2.04
Total	344	100.00

**TABLE 9**

**Mothers attitude towards feeding colostrum to the baby and  
extra diet to the mother during lactation**

Mother's attitude	colostrum		Extra diet	
	n	%	n	%
Positive	232	68.24	255	74.13
Negative	92	27.06	64	18.60
No response	16	4.70	25	7.27
Total	340	100.00	344	100.00

**TABLE 10**

**Mothers attitude towards  
the length the baby should be given breast feed**

Age of the baby in months	n	%
=> 12	300	87.21
9 - 11	14	4.06
< 8 or as long as possible	11	3.20
No response	19	5.52
Total	344	100.00



**TABLE 11****Mother's attitude towards the age of introduction of supplements**

Age of the infant (in months)	Liquids		Solids	
	n	%	n	%
<=3	5	1.45	5	1.45
3-5	109	31.69	87	25.29
6-8	106	30.8	123	35.76
=> 9	59	17.15	53	15.41
No response	65	18.90	76	22.09
Total	344	100.00	344	100.00

**TABLE 12**

**Source of information of mothers on  
INFANT FEEDING PARCTICES**

Source	n	%
Health personnel	118	31.05
Relatives	176	46.32
Mass media / own education	41	10.79
Other than the above	25	6.58
No response	20	5.26

*Note: The total responses more than the sample size as some of the mothers had more than one source of information.*



# NUTRITIONAL SURVEY OF PRESCHOOL CHILDREN IN URBAN ICDS

Wg Cdr. T.S. Raghuraman

Lt. Col. C.G. Wilson

Lt. Col. Vipin Chandar

## INTRODUCTION

Infants and preschool children constitute about 17% of the total population in our country. Malnutrition is one of the important public health problem in India, more so in this age group of children as this population contribute to almost 50% of the total deaths in pediatric age group (1). The nutritional status of the children between the ages of 1 to 5 years also reflect the nutritional situation of the community to which they belong (2).

Among the nutritional deficiencies in children, protein energy malnutrition (PEM), vitamin A deficiency, anemia and iodine deficiency disorders are the major problems of public health significance. Community studies have shown that about 2-3% preschool children suffer from clinical forms of malnutrition, while a great majority have milder grades which manifest as varying degrees of growth retardation (3). Apart from causing eye lesions, vitamin A deficiency has other important functional implications. Recent studies in children have shown that vitamin A deficiency is associated with increased risk of morbidity and mortality. Further clinical studies show that 20-30 % of the apparently normal children have low levels of serum vitamin A (20 ug/dl). (4) Similarly nutritional anemia affects a large proportion of children below 1-3 years (62.8%) (3)

The integrated child health services (ICDS), which represents the largest MCH programme in the world, has been in operation for nearly two decades. What is the impact of this service and other health programmes on the health and nutritional status of our children? This question acquires practical relevance, since children who constitute 40% of the total population, represent the most critical part of our human resources.

---

*T.S. Raghuraman, Reader*

*C.G. Wilson - Associate Professor*

*Vipin Chandar - Associate Professor*

*Department of Paediatrics, Armed Forces Medical College, Pune-411040.*



At attempt is made here to assess the nutritional status and its association/correlation with several morbidity states and nutritional deficiencies in perschool children attending urban ICDS.

## OBJECTIVES

The aim of this study was to detect various grades of malnutrition in preschool children using anthropometric indices like height, weight, weight for height, height for age, and mid arm circumference.

To correlate malnutritional status with various morbidity states like diarrhoeal disorders, respiratory infections, measles, and other febrile episodes.

To assess the incidence of various nutritional deficiency signs like anemia, vitamin A deficiency and other vitamin deficiency states.

## MATERIAL AND METHODS

(a) *Area and sampel*: Three anganwadis were selected randomly from an urban ICDS block. All the preschool children attending the aganwadis were included in the study. General information of the children and their ages were noted down from the record maintained by the aganwadi worker.

### (b) *Methods* :

(i) *Anthropometry*: the most commonly used measurements like weight, height, weight for height, height for age and mid arm circumference were noted. National centre for health statistics (NCHS) reference standard was used to assess these measurments is recommended by WHO (5)

Weight was recorded using Tansi beam balance to the nearest 50gms and grading the nutritional status was done according to Gomez classification (6).

Height was recorded by using anthropometirc rod, on which the caliberations are made in Cms (1 to 200 cms), to the nearest millimeter.

Weight for height and height for age were calculated using leanness board (5).



Waterlow's classification (7) was used to grade the malnutrition as follows:-

Height for age (% of Standard)	Weight for Height (% of Standard)	Nutritional Grade	Types of Malnutrition
90	80	Wasted & Stunted	Current long duration
90	80	Stunted	Long duration
90	80	Wasted	Short duration
90	80	normal	normal

Mid arm circumference was recorded on the left arm of the child who was asked to stand erect while the investigator stood on the left side of the child. A tricolour tape was used for measuring the circumference which has three colours at appropriate cut off points as follows:

Green - normal

Yellow - Moderately malnourished

Red - severely malnourished

(ii) Morbidity states: History of morbidity states like diarrhoeal disorders, respiratory tract infections, febrile episodes and infections like measles and whooping cough was recorded from the mother by recall of such episodes which occurred during the fortnight prior to the day of examination.

(iii) Clinical examination for nutritional deficiency signs: Each child was examined for evidence of signs like sparse hair, moon facies, emaciation, pallor, bitot's spots, conjunctival xerosis, angular stomatitis.

(iv) Association of nutritional status with morbidity states and nutritional deficiency signs : Morbidity states were noted down in each age group and in each grade of malnutrition. Similarly nutritional deficiency signs were noted down in each age group separately for both sexes and all these were analysed.

## OBSERVATION AND RESULTS

A total of 104 preschool children were studied out of which 50 were boys and 54 girls forming a percentage of 47.62 and 52.38 respectively.



(a) *Age and sex wise distribution of malnourished children*: 83 out of 104 children (79.81%) were found to be suffering from various grades of malnutrition. The largest group (50%) being those suffering from mild or grade I malnutrition. The details of all grades of malnutrition with age and sex wise distribution is given in Table I.

(b) *Type and duration of malnutrition* : It has been observed that 4 children (3.85%) were stunted and wasted, 53 (51.01%) were stunted, and 47 (45.14%) were normal as per waterlow's classification.

(c) *Nutritional status as per mid arm circumference*: the measurements of mid arm circumference with tricoloured tape showed 57 children (54.8%) as normal (green colour), 35 (33.65%) were moderately malnourished (yellow colour), and 12 (11.54%) being severely malnourished (red colour)

(d) *Nutritional status vis a vis morbidity*: It was noted that 27 children (25.96%) belonging to all grades of nutritional status had morbidity. However 100% morbidity (6/6) was observed in severely malnourished children (Table II)

(e) *Type of morbidity in various types of malnutrition*: Diarrhoeal disorders were observed in highest frequency (10.5%) in normal as well as in all grades of malnutrition followed by ARI (7.6 %). Febrile episodes accompanied both these morbidity states in majority of cases. 1 out of 6 children with grade III malnutrition had two or more morbidity states (Table III)

(f) *Morbidity in each group* : 4 out of 11 children in the age group of 2 years had shown the highest morbidity state (36.5%) in contrast to 15.79% in 4 years old male children (Table IV).

(g) *Type of morbidity in each age group* : Diarrhoeal disorders were observed most commonly in all age groups followed by ARI. Majority of the children had associated febrile episodes in both these morbidity states. Maximum children in the age group of 3 years and 4 years had suffered from 2 or more morbidity states (Table V).

(h) *Prevalence of nutritional deficiency signs* : 3 years old boys had the maximum nutritional deficiency signs (88.9%) in contrast to 1 year old girls (20%). Conjunctival xerosis formed the major group (16.35%) and the smallest group being corneal opacity (0.96%) (Table VI).



## DISCUSSION

Growth monitoring and promotion as part of the strategy GOBI (growth monitoring, oral rehydration, breast feeding, and immunization) was advocated by UNICEF in 1982. Over the years greater stress has been laid on growth monitoring by various health agencies. Malnutrition in preschool children contribute to about 50% of the total deaths in pediatric age group (1). Since the inception of ICDS in 1975, there has been significant improvement in the overall incidence of various morbidity states and nutritional deficiency states associated with malnutrition. The NNMB studies have shown a significant decline in the prevalence of grade III malnutrition from 15% during 1975-79 to 8.7% in 1988 -90, with a corresponding increase in the proportion of normal children (8). In this study grade I malnutrition (mild) was seen in 50% of children and grade III malnutrition (severe) in 5.7% a comparable figure to the study of Tandon (9). Higher incidence of malnutrition (severe/grade III) in 9.7% of girls vis a vis only 2% in boys was strikingly significant. Further girls belonging to the age group of 3 years had significantly higher incidence of malnutrition (87.5%) as compared to boys (66.67%). Similar findings have been recorded in the 1984 report of NNMB. This could be attributed to the less intake of nutrients at home and relying on supplementary nutrition being provided at anganwadis. Added to this is the bias factor of female sex.

Among the malnourished children, 51% were stunted indicating chronic malnutrition of long duration and thereby implying that growth monitoring of these children were not adequate. Another significant observation was that contrary to incidence of malnutrition as per Gomez classification (mild 50%, moderate 24.04%, severe 5.7%), mid arm circumference measurements revealed 33.65% children moderately malnourished and 11.54% severely malnourished. A similar observation has been recorded by another study (10). This highlights the importance of using age independent anthropometric measurements, particularly when the date of birth and hence age of the child is often unreliable and more weightings are done from 3-6 years rather than in the younger age, even though the problems of malnutrition and stunting are mostly in the younger children.

The study confirms the preexisting fact that morbidity state is directly proportional to the degree of malnutrition. The depressed cell mediated immunity makes children with malnutrition more susceptible to recurrent infections (11). Analysis of age wise morbidity state suggested that children in the age group 2 years had the highest



morbidity state (29.7%). Such similar observations by another worker (12) could be attributed to improper rearing to toddlers by the elder sib rather than by mother who is occupied with earning daily wages or in pregnancy state.

Vitamin A deficiency in the form of conjunctival xerosis, bitot's spot, and corneal opacity were seen in 16.35% 1.92% and 0.96% respectively. ICMR surveys in different parts of the country have shown that about 4% of the preschool children have bitot's spots and 1 in 1000 develop corneal lesions (13). Nutritional anemia seen in 14.43% of preschool children is significantly lower than the figures of a multicentric study under the auspices of ICMR that showed as many as 62.8% of children below 1-3 years and 44% between 3-5 years to be anemic (8). The significant reduction in the incidence of nutritional deficiencies could be attributed to the successful campaign of Vit A prophylaxis and national anemia prophylaxis programme being carried out in these anganwadis.

Summarising this study the following conclusions could be drawn. One, the incidence of mild and moderate malnutrition is still high. This is probably as a result of improper growth monitoring and promotion. Two, the prevalence of overt cases of malnutrition like kwashiorkor and marasmus is significantly less as a result of the health intervention programmes. Hence attention and the resources could be diverted to those children with growth failure, the incidence of which remains still high. Three, the vitamin A prophylaxis programme and the anemia prophylaxis programme have made considerable impact and thereby reducing the morbidity due to two important nutritional deficiencies.

Since the prime aim is to improve the health and nutrition of children, specific inputs regarding these such as advice regarding breast feeding, improving mother's knowledge regarding nutritional requirements of children, food intake during and after an illness, helping mothers to do this keeping in mind other variables of income, food taboos, dietary pattern of the family, constraints of time, etc. Prevention and early management of morbidity, preventive measures such as immunization, environmental sanitation, safe water are crucial. Children in the age group 0-3 years be made the priority group for all the above mentioned health intervention measures.



## REFERENCES

1. Studies on preschool children. Indian Council of Medical Research Tech Rep Ser No. 26, 1974, p 17.
2. Someswara Rao K, Swaminathan MC, Swarup S, and Patwardhan VN. Protein Malnutrition in South India. Bull W.H.O 1959, 20: 603-639.
3. Studies in preschool Children. ICMR Tech Rep Series 1989, No 26.
4. Reddy V, Rao V, Jyoti A, Reddy M. Conjunctival impression cytology for assessment of Vitamin A status. Am J Clin Nutr. 1989, 50:814-817.
5. World Health Organisation. Measuring change in nutritional status Geneva, WHO, 1985,
6. Prasad R, Mathur PP, Prasad J. assessment of nutritional status of preschool children. J Trop Pediatr 1982, 28:199-201.
7. Waterlow Jc. Note on the assessment of classification of PEM in Children. Lancet 1973, 11: 87-89.
8. National Nutrition Monitoring Bureau. Report of repeat survey. National Institute of Nutrition, Hyderabad, 1991.
9. Tandon Bon Nutrition intervention through primary health care. Impact of ICDS projects in India. Bull WHO 1989, 67:77-80.
10. Anderson MA, Gopaldas T, Abbi R, Gujral S. Agreement between Arm circumference, weight for age, and weight for height - Measure: of malnutrition in children. Indian Pediatr, 1989, 27:247-254.
11. Srianktia SG. Nutrition and infection. From nutrition proceeding of seminar, Bombay, Nov 1976, 17-23.
12. Kapil V, Sood AK. Morbidity pattern in children below three years attending a rural health center in Haryana. Indian Pediatr. 1989, 26: 550-552.



**TABLE - 1**  
**DISTRIBUTION OF PRESCHOOL CHILDREN AND THEIR NUTRITIONAL STATUS AND THEIR CLASSIFICATION**

Age in Sex Years	Number	Nutritional Status (percentage of Baby weight for age)			Grade III (60%)	Total Malnourished Children
		Normal (90%)	Grade I Malnutrition. (75-90%)	Grade II (60-75)		
1. Male	12	2 (16.56)	7 (58.33)	3 (25.01)	- (85.37)	10
Female	15	3 (20)	7 (46.66)	4 (26.27)	1 (667)	12 (80)
2. Male	11	3 (27.27)	5 (45.46)	3 (27.27)	- (72.73)	8
Female	16	3 (18.75)	9 (56.25)	3 (18.75)	1 (6.25)	13 (81.25)
3. Male	9	3 (33.33)	5 (55.56)	-	1 (66.67)	6
Female	8	1 (12.5)	3 (37.5)	2 (25)	2 (25)	7 (87.5)
4. Male	19	3 (15.79)	9 (47.37)	7 (36.84)	- (84.21)	16
Female	14	3 (21.43)	7 (50)	3 (21.43)	1 (7.14)	11 (76.57)
Total	104	21 (20.19)	52 (50)	25 (24.04)	6 (5.7)	63 (79.81)

Figured in parenthesis indicate percentage



**Table II**  
**NUTRITIONAL STATUS AND MORBIDITY IN PRE SCHOOL CHILDREN**

S.No.	Nutritional Status	State of Morbidity	
		Morbidity No:27	No Morbidity No:77
1.	Normal (n=21)	3 (14.3)	18 (85.7)
2.	Grade I - Malnutrition (n=52)	8 (15.38)	44 (84.62)
3.	Grade II - Malnutrition (n=25)	10 (40)	15 (60)
4.	Grade III - Malnutrition (n=6)	6 (100)	-

Figures in parenthesis indicate percentage.

**TABLE -III**  
**TYPE OF MORBIDITY IN MALNOURISHED CHILDREN.**

S.No.	Nutritional Status	Type of Morbidity				
		Nil (n=77)	Diarrhoeal disorders (n=11)	ARI (n=8)	measles (n=2)	Febrile episodes (n=7)
1.	Normal (n=21)	18 (85.7)	1 (4.43)	1 (4.43)	-	1 (4.43)
2.	Grade I (Mild) Malnutrition (n=52)	44 (81.62)	4 (7.68)	2 (3.85)	-	2 (3.85)
3.	Grade II Malnutrition (n=25)	15 (60)	4 (16)	3 (12)	1 (4)	2 (8)
4.	Grade III Malnutrition (n=6)	-	2 (33.3)	2 (33.3)	1 (16.67)	2* (16.67)

Figures in Parenthesis indicate percentage.

\*One child with severe malnutrition had more than one morbidity state



**TABLE IV**  
**MORBIDITY STATE IN PRESCHOOL CHILDREN.**

S.No	Age in Years	Sex	No.	State of Morbidity			
				No Morbidity	Morbidity one episode	Morbidity >1 episode	Total Morbidity
1.	1+	(M)	12	8 (66.67)	2 (16.67)	2 (16.67)	4 (33.33)
		(F)	15	12 (80)	2 (13.33)	1 (6.66)	3 (20)
2.	2+	(M)	11	7 (63.63)	2 (18.18)	2 (18.18)	4 (36.37)
		(F)	16	12 (75)	2 (12.5)	2 (12.5)	4 (25)
3.	3+	(M)	9	6 (66.67)	1 (11.11)	2 (22.22)	3 (33.33)
		(F)	8	6 (75)	1 (12.5)	1 (12.5)	2 (25)
4.	4+	(M)	19	16 (84.21)	1 (5.26)	2 (10.52)	3 (15.79)
		(F)	14	10 (71.42)	2 (14.29)	2 (14.29)	4 (28.58)
		Total	104	77 (74.04)	13 (12.9)	14 (13.46)	27 (25.96)

(M) - Male (F) - Female

**TABLE 5**  
**TYPE OF MORDIBITY IN EACH GROUP OF PRESCHOOL CHILDREN.**

S.No.	Age in Years	Type in Mordibity			
		Diarrhoeal Disorders	ARI	Measles	Febrile Episodes
1.	1+	2	2	-	3
	(n=7)	(20.57)	(20.57)	(42.06)	
2.	2+	2	2	-	4
	(n=8)	(60)	(20)		(20)
3.	3+	3	1	1	-
	(n=5)	(60)	(20)	(20)	
4.	4+	4	2	1	-
	(n=7)	(57.1)	(28.57)	(14.28)	

Figures in Parenthesis indicate percentage.



TABLE VI

## PREVALENCE OF NUTRITIONAL DEFICIENCY SIGNS OF PRESCHOOL CHILDREN

S.No.	Deficiency Signs	Age in Years						Total Percentage			
		1+ (n=27) M F (n=12)(n=15)		2+ (n=27) M F (n=11) (n=16)		3+ (n=17) M F (n=9)(n=8)			4+ (n=33) M F (n=19)(n=14) (n=104)		
1.	Emaciation	1	-	2	1	1	1	-	7	6.73	
2.	Conjunctival Xerosis	1	1	3	2	4	2	2	17	16.35	
3.	Bitots spots	-	-	-	-	1	-	1	2	1.92	
4.	Corneal opacity	-	-	-	-	-	-	-	1	0.96	
5.	Anemia	2	1	2	3	1	1	2	15	14.43	
6.	Angular stomatitis	-	1	1	1	1	1	4	14	13.46	
Total No		4	3	0	7	8	5	10	11	56	53.85
		(33.33) (20)		(72.73)(43.75)		(36.89)(62.5)		(52.63)(78.57)			

Figures in Parentesis indicate Percentage.

M - Male F - Female



# BIRTH WEIGHT CO-RELATE TO MOTHER'S AGE AND PARITY - ONE YEAR URBAN HOSPITAL STUDY - KARNATAKA

*Abdul Salam, Mohd. S. Akhtar  
Vidya S. Ugran, Mumtaz A. Lashkari*

## INTRODUCTION

Birth weight is an important and reliable index which indicates foetal well being, maturity and out come of pregnancy. It is considered as one of the determining factors for future survival of neonates. WHO has defined low birth weight baby as one weighing less than 2500 gm within first hour of life (1) Neonates in developing countries like India face the risk of mortality due to LBW. The etiology of this problem is not well understood. Many etiological factors have been held responsible. Among those socio-economic conditions and lack of health care as well as health education are found to be mainly responsible. Infants in India with weight less than 2500 g at birth represent about 30 percent of all live births & this is very high when compared to 4-5 percent in industrially developed countries (2,3). Low birth weight (LBW) infants run the risk of high mortality and morbidity than infants with normal birth weight (4). The goal of the National Health Policy is to reduce the incidence of LBW infants in the country to 10 percent by the year of 2000.

In this paper an attempt has been made, to study the relation between birth weight, mothers age and parity.

## MATERIAL AND METHODS

The present study is based on data from Government Civil Hospital Which is attached to Al-Ameen Medical College, Bijapur, Karnataka. The data was collected from the hospital birth register and case sheets of delivery and birth during the period of one year (May 1991 to April 1992).

In that period a total No. of 1359 live births took place. Of the 1359 delivery cases there were 83.9% and 16% neonates belong to Hindu and Muslim respectively.

---

*Abdul Salam, Mohd S Akhtar, Vidya S.Ugran, Mumtaz.A. Lashkari Dept.of  
Community Medicine, AlAmeen Medical College, Bijapur - 586108, Karnataka*



The various variables related to birth weight included in this study are, parity, Mother's age, Religion, Family Income, Types of deliveries and sex of the babies . Statistical techniques such as, Mean, Standard Deviation, Co-efficient of variations, correlation and X2 test were used to analyse the relationship between various parameters.

## RESULTS

A total no. of 1359 live births were studied; of which 229 (16.8%) were LBW babies. The mean birth weight was 2784 g ( $\pm 452$  g) and Co-Efficient of variation was 16.4%. The sex wise ratio of male and female babies was 54 and 46 percent respectively. Mean birth weight was 2824 and 2735 g for males and females babies respectively.

Table I shows the percentage distribution of parity with birth weight. 61.4% of the infants were of parity 1. The rate of LBW was high in this parity (21.2%). The LBW rate was less for the parity 3 (5.5%) when compared to parity 2 (11.6%) parity 4 (10.0%) and parity 5 (14.7%). Correlation was analysed between parity and birth weight. Both Variables had a positive correlation ( $r=0.2244$ ), ( $p<0.01$ )

Table II shows mother's age related to birth weight. 14.7% of mothers were of 20 years age group. The LBW Rate was higher in this age group (23.1%) when compared to 20-29 years (16.8%), 30-34 years (10.3%) and >39 years of age (10.2%). Correlation was calculated ( $r=0.1370$ ) ( $P.<0.05$ ).

Percentage distribution of mortality in relation to birth weight and religion is given in Table III. Of the total 1359, cases, 83.9% and 16.1% of babies were of Hindus and Muslims respectively. The percentage of LBW babies was higher among the Hindus (17.4%) than the Muslims (14.2%). The rate of mortality of LBW neonates for Hindus and Muslims were (20.7%) and (32.3%) respectively. The data revealed that babies having birth weight less than 2500 g were more prone to mortality. In this weight group the mortality was high (22.3%). The mortality was (3.0%) and (2.0%) for the group of 2500 to 3000 gm and above 3000 g respectively. The mortality declined with the increase in birth weight.



## DISCUSSION

The LBW infants in the present study (16.8%) was less than that of other studies conducted in various places of India ranged from 20.1% to 46.4% (Table IV, 5,6,7,8,9). The rate of LBW babies in Hindus was higher (17.4%) than in Muslims (14.2%).

The incidence of low birth weight 30% in India is very high when compared to 4-5% in developed countries (2,3).

The Global current estimates of the incidence of LBW are approximate. In 1985, it was estimated that 129 million babies born during one year, & among them 20 million (15.5%) babies were of low birth weight. Nearly 50 percent of these LBW infants were born in the least developing countries (10). The rate of LBW neonates in India was higher than in other south East Asian countries like Phillipines (19.5%), Singapore (11.2%) Malaysia (9.0%) and Burma (20.0%) (4).

The mean birth weight in the present study was 2784 g ( $\pm$  452 g) and was marginally high when compared to the recorded mean birth weight from Varanasi 2628g ( $\pm$  504g), Calcutta 2673 g ( $\pm$  394 g), Baroda 2449 g ( $\pm$ 520 g), Bombay 2597 ( $\pm$ 441 g) (8) and it was quiet low to the studies conducted in Iraq (11) and Pakistan (12). It is quite evident from the present study that birth weight of babies is dependent on mother's age and parity. The babies with LBW was 23.1% in the age group of less than 20 Years and low (10.4%) in group of above 30 Years age (Table II). The Prevalence of LBW babies was high among the first para women when compared to the consequent para women (Table I). The similar trend is further strengthened by different workers (4,5,11,12,13).

The birth weight of the new born reflects the state of mother's age, parity, health, nutrition and antenatal care given. Low birth weight (<2500 g) infants run the risks of high mortality than neonates with normal birth weight (4). In the present study of the 229 babies with low birth weight (<2500 g) mortality rate was 22.3% and in babies with higher birth weight (>2500 g) mortality rate was 3.3%. The rate is low when compared to studies conducted by Trivedi etal (3).

The deep insight into available literature reveals that the low birth weight is nearly always the result of Socio-Economic status, insufficient antenatal care, nutrition, mother's age and parity, traditional



beliefs insufficient birth space and adolescent pregnancy), occupational stress and unhygienic practices (personal) hygiene, chewing tobacco, smoking. If not all these factors atleast few of this definitely contribute to the increased number of LBW babies and thereby inviting the risk of mortality among these babies.

The analysis of the present study data clearly revealed that the mortality rate sharply declined with the increase in birth weight. The LBW babies strongly depends on mother's age, nutritional status of mother, overall health of mother and antenatal care provided to her.

## REFERENCES

1. International Classification of Diseases. W. H. O 1977
2. Govt. of India, Ministry of Health and Family Welfare (1984). Annual Report 1983-84.
3. Trivedi CR, Mavalankan DV. Epidemiology of low birth weight in Ahmedabad. *India J Pediatr* 1986, 53: 795-800.
4. Schelp FP, Pongpaew P. Analysis of low birth weight rates and associated factors in a rural and an urban hospital in Thailand. *J Trop Pediatr* 1985, 31: 4-8.
5. Surainder YA, Prasad SK, Hymavanthy V. A study of gestational age and birth weight. *Indian Pediatr* 1970, 7: 338-346.
6. Srinivas DK, Damabaler M, Ganansujayam M et al. Influence of mother care, parity, and birth weight on neonatal mortality - A prospective study in an Urban hospital. *Indian J Med Res* 1976, 64: 358-368.
7. Mittal SK, Singh PA, Gupta RC. Intrauterine growth and low birth weight criteria in Punjabi infants. *Indian Pediatr* 1976, 13: 679-681.
8. Collaborative study on high risk pregnancies and maternal mortality (Institutional Study). ICMR Task Force Study, ICMR, New Delhi, 1990.
9. Kamaladoss T, Abel R, Sampathkumar V. Epidemiological Correlates of low birth weight in rural Tamil Nadu. *Indian J Pediatr* 1992, 59: 299-304.
10. VII Report on the world Health Situation, WHO 1987, Vol I.



11. Ramakutty P. Tikreeti RAS, Rasam KW et al. A study on birth weight of Iraqi Children. J Tropediatr 1983, 29: 5-10.
12. Nagra SA, Gilani AH, Ahmad MD, Haq EV. A longitudinal study in body weight of Pakistani infants as influenced by Socio economic states. J Trop Pediatr 1984, 30: 217-220.
13. Strahan M. Birth weight in a rural Solomon Island Population. J Trop Pediatr 1984, 30: 293-295.

**TABLE I**  
**PERCENTAGE DISTRIBUTION OF BIRTH WEIGHT WITH PARITY**

Birth Weight in gm	P A R I T Y						Total
	1	2	3	4	5	6	
<1000	3 (0.4)	-	-	-	1 (5.9)	-	4
1000 - 1500	15 (1.8)	1 (0.4)	-	1 (1.7)	-	-	17
1500-2000	40 (4.8)	8 (2.8)	-	-	1 (5.9)	1 (5.9)	50
2000-2500	119 (14.3)	24 (8.4)	8 (5.5)	5 (8.3)	1 (5.9)	1 (5.9)	158
2500-3000	471 (56.5)	163 (57.2)	94 (64.4)	31 (51.7)	7 (41.2)	7 (41.2)	773
3000 -3500	163 (19.5)	69 (24.2)	36 (24.7)	19 (31.7)	5 (29.4)	4 (23.5)	296
>3500	23 (2.7)	20 (7.0)	8 (5.4)	4 (6.6)	2 (11.7)	4 (23.5)	61
Total	834 (100)	285 (100)	146 (100)	60 (100)	17 (100)	17 (100)	1,359

$r = 0.224.4$ ;  $X^2 = 73.41$ ; (p.0.01) (Significant)  
Percentage in Paranthesis



**TABLE - II**  
**DISTRIBUTION OF BIRTH WEIGHT WITH MOTHER'S AGE**

Birth weight in gm	Mother's age in years					Total
	<20	20-24	25-29	30-34	35>	
< 1000	1 (0.5)	1 (0.2)	1 (0.2)	1 (0.8)	-	4
1000-1500	4 (2.0)	7 (1.4)	6 (1.3)	-	-	17
1500-2000	6 (3.0)	26 (5.0)	11 (2.4)	5 (3.7)	2 (3.4)	50
2000-2500	35 (17.6)	58 (11.2)	53 (11.8)	8 (6.0)	4 (6.8)	158
2500-3000	111 (55.8)	291 (56.2)	269 (59.8)	71 (53.4)	31 (52.5)	773
3000 -3500	36 (18.1)	115 (22.2)	93 (20.7)	36 (27.1)	16 (27.1)	296
>3500	6 (3.0)	20 (3.8)	17 (3.8)	12 (9.0)	6 (10.2)	61
Total	199 (100)	518 (100)	450 (100)	133 (100)	59 (100)	1,359

$r=0.1370$ ;  $X^2=35.9$ ; (P 0.5) Significant)  
Percentage in Paranthesis



TABLE - III

## DISTRIBUTION OF MORTALITY IN RELATION OF BIRTH WEIGHT &amp; RELIGION

Birth weight in gm	Total Births			Mortality		
	Hindu	Muslim	Total	Hindu	Muslim	Total
<1000	4 (0.4)	-	4 (0.3)	3 (75.0)	-	3 (75.0)
1000 - 1500	16 (1.4)	1 (0.5)	17 (1.3)	6 (37.5)	-	6 (35.3)
1500-2000	40 (3.5)	10 (4.5)	50 (3.7)	12 (30.0)	6 (60.0)	18 (36.0)
2000-2500	138 (12.1)	20 (9.1)	158 (11.6)	20 (14.5)	4 (20.0)	24 (15.2)
2500-3000	641 (56.2)	132 (60.3)	773 (56.9)	25 (3.9)	5 (3.8)	30 (3.9)
3000-3500	256 (22.5)	40 (18.3)	296 (21.7)	4 (1.6)	-	4 (1.4)
>3500	45 (3.9)	16 (7.3)	61 (4.5)	2 (4.4)	1 (6.3)	3 (4.9)
Total	1,140 (100)	219 (100)	1,359 (100)	72 (6.3)	16 (7.3)	88 (6.5)

Percentage in Paranthesis

TABLE - IV

## MEAN BIRTH WEIGHT AND INCIDENCE OF LOW BIRTH WEIGHT IN INDIA

S.No	Author	Year	Place	Percentage of LBW.	Mean Birth weight.
1.	Surainder (5)	1970	Hyderabad	33.2	2710
2.	Srinivas (6)	1976	Pondichery	22.0	2625
3.	Mittal (7)	1976	Ludhiana	24.5	2974
4.	ICMR (8)	1990	Delhi	25.1	2769.545
5.	-do-	"	Varanasi	30.6	2628.504
6.	-do-	"	Calcutta.	20.1	2673.394
7.	-do-	"	Baroda	46.4	2449.520
8.	-do-	"	Bombay	34.9	2597.441
9.	Kamaladoss	1992	Madras	24.6	2720.440



# **CHILD LABOUR IN SIVAKASI**

Happy child is a nation's pride. "Today's children are tomorrow's citizens". These wishful and optimistic slogans look shallow and morbid when one encounters in everyday reality of children working in tea stall, as rag pickers, as news paper hawkers, as labour force in unorganised and organised sectors of economy.

In this context the term and reality of 'Children Labour' a twin concept amalgamating two antithetical reality validates paramount importance. It is a stage when the child needs love and protection, but he is pushed into manual labour. This is because they are made to contribute to the accumulations of capital by sacrificing their childhood as soon as they are able to coordinate their organs.

What is child labour? The concept of child labour is not simple as it appears to be. Child labour has been defined differently on different occasions, acts, industries, etc. Child labour is hateful and exploitative. The work performed by children either endangers their health or safety. It is the wage labour of the underaged.

## **MATCH AND FIRE WORKS IN SIVAKASI**

No other issue concerning Sivakasi has been exposed in the Media so much as child labour.

The working conditions of Sivakasi's working children have been exposed by many journalists and a few commissions that were appointed specifically for that purpose.

In most cases children work in cramped unhygienic and unsafe surroundings of factories. They work in an average for 12 hours a day, feverishly to ensure maximum output for the payment of wages on piece rate system. In a majority of the places about 60% of the workforce is comprised of children and on the whole 90% of the workforce are women and girl children, whereas child workers comprise about 30% of the workforce in fireworks. These workers are brought to Sivakasi everyday from villages as far as 50 Kilometers. The factory owners have village level agents who act as employment agents and also to wake up and send children for work every morning. Advances are paid to the parents through these agents, which act as a binding on them to send their children for work until the advance is cleared.



In Sivakasi region apart from matches and fireworks, another industry which employs more children is printing. As the source of labour for all the three industries is the same, there is a linkage among them in terms of labour relations, which is an essential feature contributing to the very high incidents of child labour. The occupations in which children are employed in Sivakasi do not require any special skill, and they start working at the age of seven especially girls. Boys are also employed in the match industry, but they join mainly in the printing industry and allied activities as helpers, carriers and so on, besides the fireworks industry. As most of these children do not even have primary education-a fact established by the studies on child labour in Sivakasi - they grow up without acquiring any specific skills for a career and land in low paid jobs. In the case of females, most of them continue to work in the match or the fireworks industry but they attain maximum productivity in their early twenties. After this their wages also stabilise at a low level when they get married and have children, whom they are forced to send for work. Thus it becomes a vicious circle. The entire household economy revolves around these industries and there is no way out.

This vicious circle is also determined by the wage levels. The children in the printing industry start on Rs. 250/- a month and the average wage of adult worker is about Rs.450/- The maximum wage at the end of one's service is about Rs.800/- per month. In many cases workers do two shifts continuously for earning more money. All the members of the family, including the children are employed for their subsistence. Hence improving the working conditions and the wage levels of adults is an essential step to eradicate child labour.

The Govt of India has formulated the National Child Labour project in Sivakasi area at an estimated cost of Rs.13.89 crores for a period of three years of commencing from 1986-87 which was launched by the then Hon'ble Union Minister of State for labour at Sivakasi on 20.4.86.

## **HISTORY OF THE PROBLEM**

The problem of child labour in Sivakasi area dates back to several decades when match industry was born. The District being drought prone and most backward the match manufactures could capitalise on the weak agricultural base to their maximum advantages. So match industry held grater promise of employment and occupation. Women and children were predominantly employed both at factory and at



home. In Sattur, Sivakasi and surrounding villages to which the industry has spread, most of households look like industrial sheds. Here 70% of the country's requirement of matches is manufactured. Every home is an industry. Thus Sivakasi earns the name "Mini Japan" and 'Chotta Japan'. Match and fireworks industries employ nearly three lakhs of people in the area. The objectives of development viz improved quality of life of the working class to help themselves and control their own destinies still remain an unrealised dream till this day.

At the factory level, the Act is often violated with immunity. The child is deprived of the pleasures of childhood. The legislative protection against child labour is weakly enforced. The enemies of child labour argue and most people in these parts are of the view that a blanket ban on child labour is neither feasible nor desirable - a view also held by the National Seminar on Employment of Children in Nov.1975. The children coming from the villages to work in Sivakasi and Sattur towns, come to the workspot early in the morning and go back home after dusk. They are deprived of the opportunities for physical, mental and moral development. They repeat the cycle of their parent's misery, illiteracy, large families, low standard of living and social life. The link between education, deprivation and low income is in evidence. The strange industrial culture of Sivakasi which is a deep rooted one where every poor parent is compelled to send his child to the match and fireworks factory for employment rather than to the schools, needs to be changed.

## **SURVEYS AND STUDIES**

The M.S.Gurupadasamy Committee on child labour in 1979 noted that the laws governing employment of children were not enforced and that the number is on the increase. It called for a purposeful policy decision and systematic evaluation without which there could be no qualitative change in the situation.

Six years later in 1986, comprehensive legislation on child labour was passed.

According to estimates, the child labour population in and around Sivakasi was 45,000 out of the total work force of 1.5 lakhs.

The National Child labour project Society was registered on 18.4.86 under the chairmanship of the Collector, Kamaraj District with the District Officers and non-officials concerned.



Various income generating projects are implemented as follows:

- a. The I.R.D.P. type of loans.
- b. Self employment programme for urban poor.
- c. Employment Generation Schemes.

## **SPECIAL SCHOOLS FOR CHILD LABOURERS**

A number of special schools were organised in Sivakasi, Sattur and Vembakottai block from 24.9.88. The special schools are imparting non-formal education alongwith vocational trades like tailoring, handicraft, carpentry, electric wiring, book binding etc.

## **NUTRITIONAL STANDARDS**

For special school children, a provision of Rs.2/-per meal per student is made available. The child workers in the factories have to care for themselves as in the case of adults and adolescents. They bring some food from home, which for all we know, will be far from the required nutritional standards.

## **HEALTH CARE IN SPECIAL SCHOOLS**

A part time Doctor has been provided for all special schools on a remuneration of Rs.500/-p.m besides providing Rs.3/-per student per month for the purchase of medicines. For child workers in the factories, the E.S.I. benefit is being made available. There is one E.S.I. hospital in Sivakasi but there is no such facility in Sattur. One has to go to Sivakasi from Sattur and Vembakottai to avail medical facilities under the E.S.I.

In order to assess the morbidity condition of the students, the Medical Officers of PHCs, in Sattur, Vembakottai and Sivakasi blocks were requested to contact the special schools for medical checkup and treatment.

The morbidity pattern among the students in special schools are given below

a.	Worm Infestation	8%
b.	Glossitis	7%
c.	An.Stomatitis	9%
d.	ASOM	6%
e.	P.U.O.	2%



f.	Carries teeth	3%
g.	Tonsilitis	2%
h.	Scabies	2%
i.	Others	22%
j.	Eye defects	4%
k.	Postural defects	5%
	NAD	34%

## **SUGGESTIONS IN GIVING MEDICAL CARE**

The amount given to parttime Doctor may be utilised to purchase medicines by utilising the services of the nearby Govt.Primary Health Centre Doctors.

## **WAYS AND MEANS TO ELIMINATE CHILD LABOUR**

- i. As a result of the study sponsored by the ICSSR in Sivakasi region 1986-87 the system of child labour could be eliminated by improving the economic conditions of parents. The study shows that incidence of child labour is much less in a village where the agriculture base is relatively better and literacy level of parents are high with viable income, compared to a backward village with poor agricultural base and high rates of illiteracy.
- ii. Legislation will not help in reducing the child labour unless it is also combined with a package of schemes to improve the economic base of the parents.
- iii. The Keeraiyam scheme to construct a dam in the western ghats to divert the west flowing water to the east is pending for over four decades now and there are a number of minor irrigation schemes that could be developed here.
- iv. An immediate step would be to get a better deal for the adult workers of sivakasi.
- v. Adult wages should be increased as the same remain at a low level.
- vi. The employers here are intolerant of any trade union activity. The preponderance of child labour acts as a check against such activity.
- vii. Certain welfare schemes could do some good for the working children. 26 schools, special schools run under the National Child Labour Project provide some optimism. There are 1800



children in these schools. A monthly stipend of Rs.100/-is paid to each besides one meal a day. Five years of elementary education is condensed to three years. A visit to a few such schools near Sivakasi revealed that most children are drawn from the match industries. The general standard also seemed better than in normal schools. This kind of schemes could be extended to cover more areas of high incidence of child labour.

- viii. Anti-social practice of child labour should be banned in a phased manner.
- ix. Mechanising the industry is good.
- x. The state Government should pass legislations in this regard, specifying a time limit, say five years, for the complete removal of children from the factories, accompanying other development schemes in order to improve the income levels of the adults.
- xi. By continuing 'Arivoli Iyyakkam', the awareness of child labour - demerits of the deed may be created so as to cut the spread of child labour in future.
- xii. To motivate parents for family welfare planning and to combat social evils and protect their children's health.
- xiii. The Yoga and other physical exercises included could help them to correct the postural deficiencies that could crop up during their work at factories with erroneous postures.
- xiv. The parents should be provided with opportunities of improving their earning with poverty alleviation programmes like the Integrated Rural Development programmes and the self employment programmes.
- xv. Interviews with the various Government officials reveal that there is a constant interference by local politicians.
- xvi. Another limitation in the programme like I.R.D.P. is that the amount given to the beneficiary is being diverted to other uses. It should be ensured that the amount sanctioned is utilised for that purpose only.
- xvii. Turning to child labour legislation the weak enforcement of it is contributed by many factors. Important among them are scattered manufacturing units, under staffed inspectorate, multiple responsibility of the inspectorates and varied perception of child



labour by parents, employers and the inspectors. Besides unsuccessful prosecutions, the pressure of industrial lobby on the overworked and less motivated inspectors, discourage them from carrying out their work efficiently and effectively.

In Sivakasi, almost all the cases got acquitted for the following reasons:

- a. Age of the child not being proved.
- b. Factory Inspector is not considered as an authority to fix the age of the child labour, his fixing of age was not accepted.
- c. Certifying surgeon of Inspectorate of factories having not fixed the age of child labour as per Modi's Medical Jurisprudence and Toxicology based on teeth, height, girth, voice bone growth, growth of hair etc.
- d. When many prosecutions are unsuccessful, Inspectors are discouraged to prosecute to avoid the risk of failure and employers are encouraged to continue to engage children. Though there are laws to deal with child labour implementation of the Acts tells a story of official apathy and tacit collusion with a mighty match industry lobby.



## **Section II**

---







# HEALTH EDUCATION & PROMOTION FOR THE SCHOOL AGE CHILD AN INTERNATIONAL PERSPECTIVE

*Colin L. Yarham*

## 1. INTRODUCTION

On a world-wide basis there is deep concern about the health of children. The horrendous erosion of the well-being of the young in misuse of drugs, by starvation and disease and in abuse and maltreatment is not only causing anguish to thinking individuals but is prompting action to assist in overcoming these problems. Understanding how best to reach, motivate and empower them with health knowledge during the critical period of their lives-before it is too late and the cost to society becomes unbearable-is one of the central challenges in the decade ahead. (Grant,1991).

The purposeful intergration of school and community efforts indeed may be a critical element in a formula to promote the health of school-aged children and youth, for it is important that the school should be regarded as a social unit providing a focal point to which health planning for all other community setting should relate. (Fig.1).

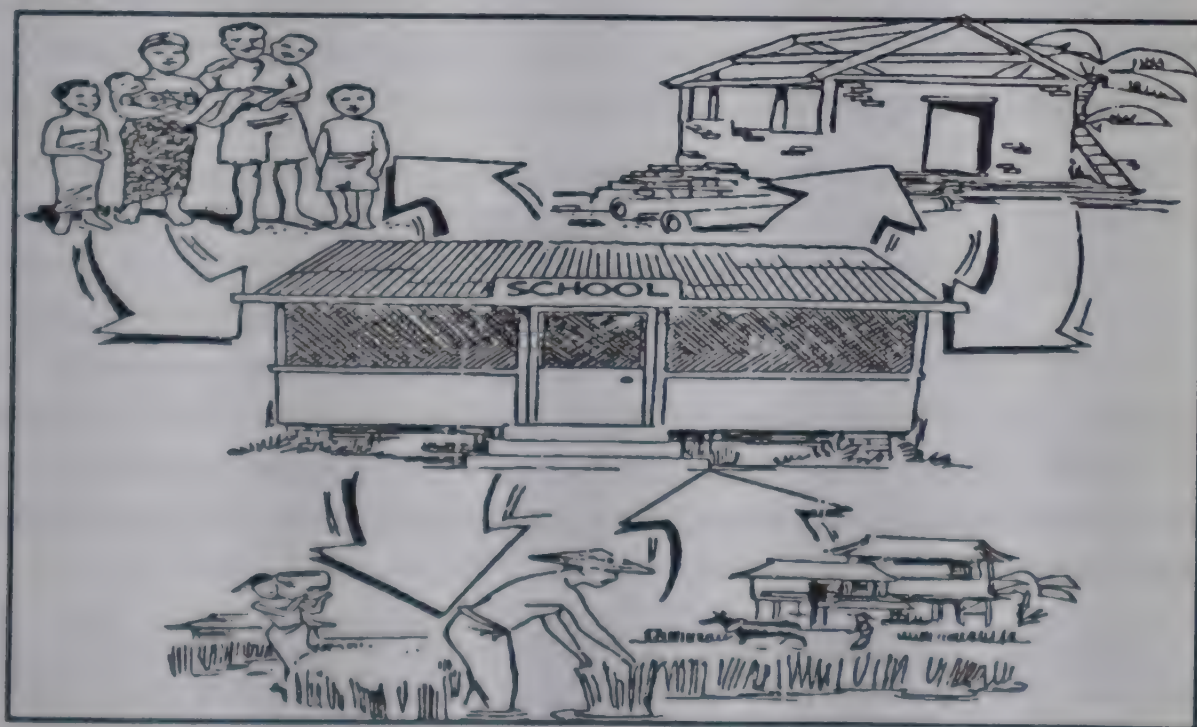


Figure 1: School and Community Interaction.

*Colin L. YARHAM, Consultant, Health Education and Promotion, P.O. Box No. 78, Rose ville NSW 2069, Australia.*



In developing countries and in developed countries, in urban streets and in rural village, the need for well-developed programs for the school-aged child is seen as paramount. Strongest efforts will be required to pass on knowledge, confront attitudes and develop skills in relation to overcoming the myriad of health and nutrition problems which are so evident (eg respiratory infections, diarrhoeal disorders, skin diseases & AIDS) but also in improving the quality of life of the individual.

The Framework for Action section of the World Declaration On Education For all suggested priority actions including: "45.b.National Efforts and related intercountry co-operation to attain a satisfactory level of quality and relevance in primary education." The Delhi Declaration of December 16, 1993 referred to the need for socially relevant education for all primary school children by the year 2000. Prime Minister Narasimha Rao called it a "Unique investment in the future" President Dr Shankar Dayal Sharma emphasised the need for a co-ordinated approach to universal primary education incorporating attention towards improved levels of nutrition, health and social attitudes. Note the constant plea for relevance.

The Director General of the World Health Organization stated unequivocally at the World Conference on Education for All (1990) that "education of children for health through schools should receive the highest priority" and the WHO Eighth General Programme of Work (1990-95) noted that "to do this requires intersectoral collaboration, particularly in strengthening health education of the school-aged child."

Helping a Billion Children Learn About Health, the report of the WHO/UNICEF International Consultation on Health Education for School-aged Children (1986) and the Policy Statement of the International Union for Health Education on health education for the school-aged child (1987) both clearly recommend the development and publication of manuals for teachers. A resolution, unanimously agreed to at IUHE World Assembly (Helsinki, 1991) further espoused this action. It is suggested that insularity between nations can no longer be countenanced.

Although the challenges for world-wide health promotion & education are great, if we work concertedly, as partners, we may be able to provide the children of all nations the chances for a better quality of life. (Kolybine, 1991) This is a challenging project which will require vision, leadership, management, co-ordination and finance. It is also one which will create movement from rhetoric to purposeful action.



## 2. JUSTIFICATION

"The needs of children, and particularly of those millions of children who are still living and dying in malnutrition and ill health as the twentieth century draws to a close, should have first claim on our concerns and capacities." -UNICEF, (1990), The state of the World's Children. Reports continue of children living in deplorable conditions, 170 million young people being malnourished, 10,000 children being forced to train as soldiers, young girls in need, unwanted pregnancies, abortion, sexually transmitted diseases/AIDS, and drug/substance abuse. Action is essential and health education for the school age child must be central to any such action.

In the youth of every nation we have an irreplaceable resource which must be developed to its full potential. The decisions people learn to make, and the behaviours they adopt during childhood and youth, have a profound effect on their health as adults and have a cumulative impact on the length and quality of life of the individual. Thus, it is essential that, if we are to move towards the World Health Organization goal of "Health for All by the Year 2000", for the world's adults of tomorrow, then a well-planned, sequentially-developed health curriculum for the 5-18 years old children in classrooms (and outside classrooms) throughout the world, must be provided. This is the body we have in this life. It is essential that we all learn the rudiments of its care. (Yarham, 1987).

The complexity of modern urban society with living, transportation and work environments constantly changing, presents huge problems for the world's ever burgeoning youth population. Youth in rural communities face equal stress in dealing with change, ever-evolving technology and environmental dysfunction. As well, socially and economically disadvantaged youth groups and individuals in developed and developing countries have fewer skills and resources to cope with demands of society. Thus an all-out effort is needed to communicate with and amongst the young regarding health and lifestyle augmentation. Not least is a need to reach out to the creative spirit and imagination of youth so that they may meet on equal terms with others.

When we think about health there are three concepts which must be considered. We must think wholistically of the health of the whole person-of all of the dimensions of health; physical, emotional, social, intellectual and spiritual. In this way school health education efforts may encourage a full and positive lifestyle, inciting children to become



all that they are capable of becoming; living much more fruitful lives. Health may be seen as a resource for everyday life. Secondly, in all societies we can no longer afford the high cost technology of curative medicine alone. It is a drain on the economy of every country and a seeping wound on the resources of each person. And thirdly, we must recognise that most of the world's major health problems and premature deaths are preventable through changes in human behaviour. If children and families could be supported, informed and motivated, millions of children who die every year could be saved - by immunization, by oral rehydration and by better dietary habits.

Investment in the future requires emphasis on 'energisers', of which education is the basis. In view of the present signs of stagnation or even deterioration of educational coverage and quality, there is an urgent need for setting priorities in education and implementing programs for improvement. (Hallak, 1990).

### 3. GOALS

A school health education and promotion program should have clear goals in enhancing:

- the development of self-reliance and responsibility in each child for their own health and that of their families and community.
- the recognition of health as an essential life asset and a primary concern for an optimal quality of life,
- the development of value systems rooted in social justice and committed to health for all, and the development of living skills to empower each individual child with the means to an improved quality of life.

As emphasised by James P. Grant (1991), it is important that we take advantage of the 'windows of opportunity' to place emphasis on human-centered development - development measured by greater equity, empowerment of individuals and communities and the improved health of women and children.

The program must have well-defined and yet evolving strategies to meet the needs of school-aged children. It should provide relevant knowledge as a background to work on development of positive attitudes and values regarding personal and community health and teach skills and patterns of practical health behaviour. It must involve the child actively. It must reach out in a realistic way to the home and the community. (see Fig. 1).



"The aim of the teaching must be that the pupils should develop the capacity to act, jointly with others and separately to promote their own and others' health. "(Statement, 1989) As suggested by Dr Linda Pfeiffer (1991), it is felt that children can serve as an important catalyst for change, because they are not only more receptive, they are also influential within their families and their community at large. Attention is particularly drawn to the Keller & Mwambazi (1984) study discussion and recommendations from Zambia (see appendix). The idea expressed have world-wide relevance. Therefore, one urgent task is to place school health high on the educational agenda & reinforce evidence which proves that well-planned, effective school health education programs make an important difference to the health of children and indeed to the community.

Participation and involvement is a keynote of planning. True participation is when all parties may be involved in decision-making and planning. Educational development must be solidly anchored in local traditions and values (Hallak, 1990) and the regionalization of curriculum development is predicated on the need to meet this criterion. All too often training programs in health education are conducted for, rather than with, participants. Planning workshops envisage the development of participants as 'partners in progress' (Oladepo, O, et al, 1991) which may facilitate appropriate program evolution as well as furtherance of participant's skills in program planning. It is thus hoped that the use of this approach will, in turn, encourage its use in the program itself as well as in its later application for it is imperative that teachers have a personal investment in the programmes they teach.

A systematic approach to development of communication strategies and programs is an imperative. This is particularly necessary where cross cultural factors and practices regarding health are concerned. Sensitivity and effort are needed in identifying ethical, moral and legal factors which may affect the two-way communication required to obtain changes in health practices.

The experience we have gained with Facts for Life only confirms the need to obtain thorough knowledge of the needs, conditions, customs and particularities of target populations. Ultimately, it is at the level of the individual, the family and the community that health messages have their effect. For that reason, communication planning must draw on detailed data about people's attitudes and conditions, needs to be as decentralized as possible and involve the target populations at every stage of the campaign. (James p. Grant, 1991)



Effective and functional co-operation and co-ordinated effort is needed between the Ministries of Education and Health at every level in school health education work. But most importantly there must be a political will with high priority, active conviction and provision of resources. Too frequently, large fund allocation goes to the high cost technology of curative medicine instead of health promotion. Leader of vision and resource are required to place due emphasis on not only preventive health but also constructive health effort.(Fig. II) With the development of region specific school curriculum guidelines, advantage may be taken of the new political will to accelerate human progress, so evident today to obtain this co-operation. Effort is required to garner the backing of influentials/administrators which is so necessary to obtain implementation of the programs.

A key element in the program is the pre-service training of teacher for this important task. It should be included in the curriculum for all teachers, but specialist health educators, who have the welfare of the child at heart, who are motivated to do the work and who are adequately trained are essential. Continuous backup support with inservice programs and resources is a natural corollary. The development of regional school Health Education Networks with the establishment of key co-operating training colleges/universities who will facilitate both preservice and inservice training programmes is desirable. The proposed guidelines from each region should equip teachers and school health co-ordinators so that they will introduce and improve relevant programs of health education & promotion in schools of the region by providing detailed information about curriculum organization and development and healthy school promotion strategies.

#### **4. THE TOTAL SCHOOL HEALTH EDUCATION AND PROMOTION PROGRAM**

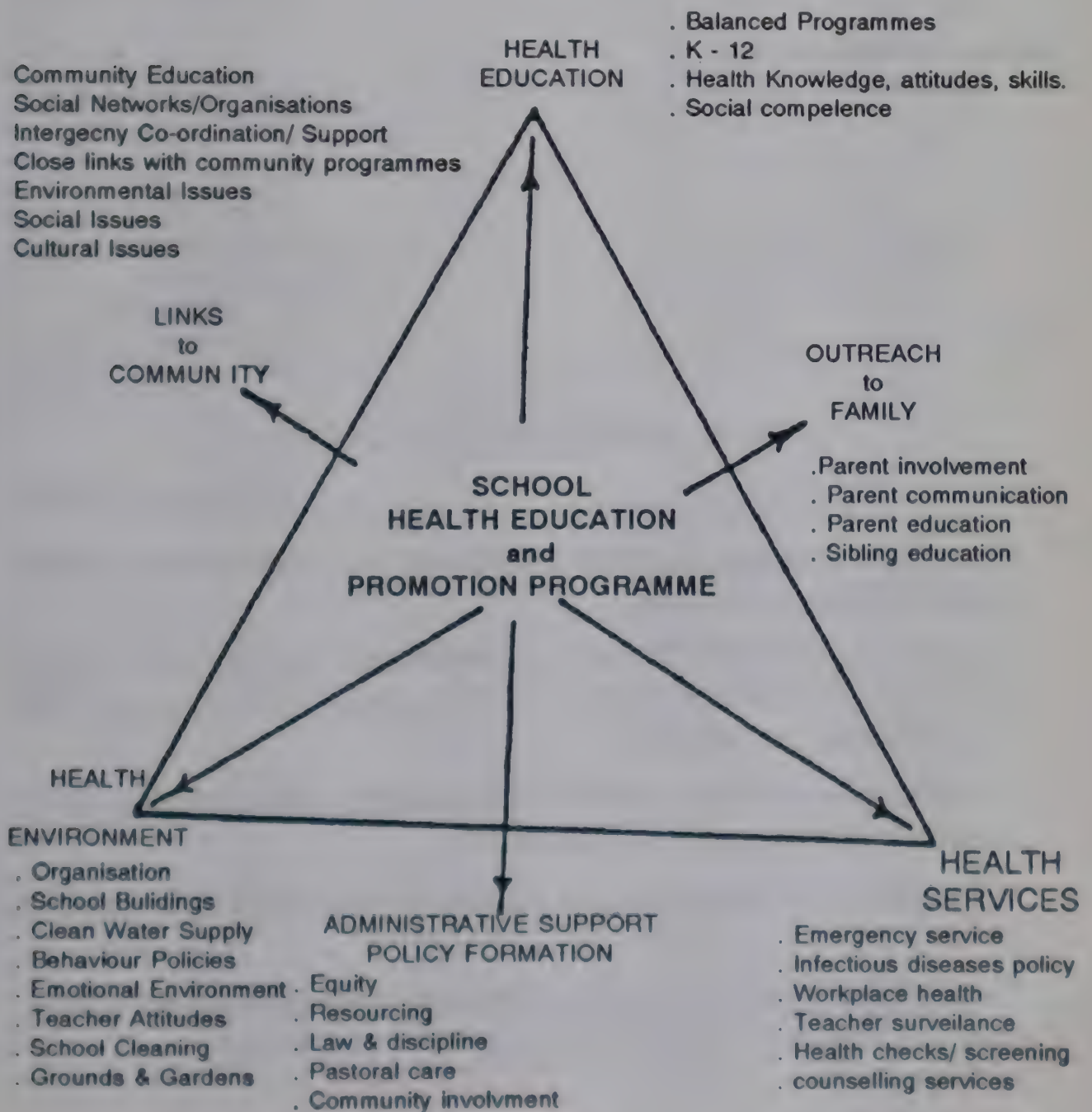
While the project with which I am enagaged has as its focus the development of a realistic school curriculum, for all ages, in schools of all sizes, with a wide variety of facilities, it also aims at provision of a supportive school health environment conducive to appropriate social change and a determination that the school embrace such change. It will become a model for outreach into the community at large.

The initiative, given the title of the Healthy Schools Program, was commenced by the Euro Office of WHO in Copenhagen and has been developed strongly in various countries in Europe. The ideas have spread to a number of areas world-wide. An example of this comes in the booklet 'What Makes A Healthy Schoold Community' produced by the NSW Health Department in Australia.



The facets of the total school health program are encapsulated in Figure II. Due emphasis must be given to each element, with thought being given on the best methods of maintaining close links with the community and determined outreach to the family. Many attitudes may come into the 'Caught not taught' category. It is thus imperative that a sound example is provided by the school health environment and the health services areas. All of the work will be of negligible value if a sound ongoing teaching program is not in place and it does not receive solid administrative support. The individual points within each category deserve close consideration.

Figure II: FACETS OF THE TOTAL SCHOOL HEALTH PROGRAMME.





## 5. PROGRAM DEVELOPMENT CYCLE

A cyclic problem-solving approach to program development is recommended (Fig.III) for it permits a process that is developmental, continuous and iterative in character.(Yarham,1980)

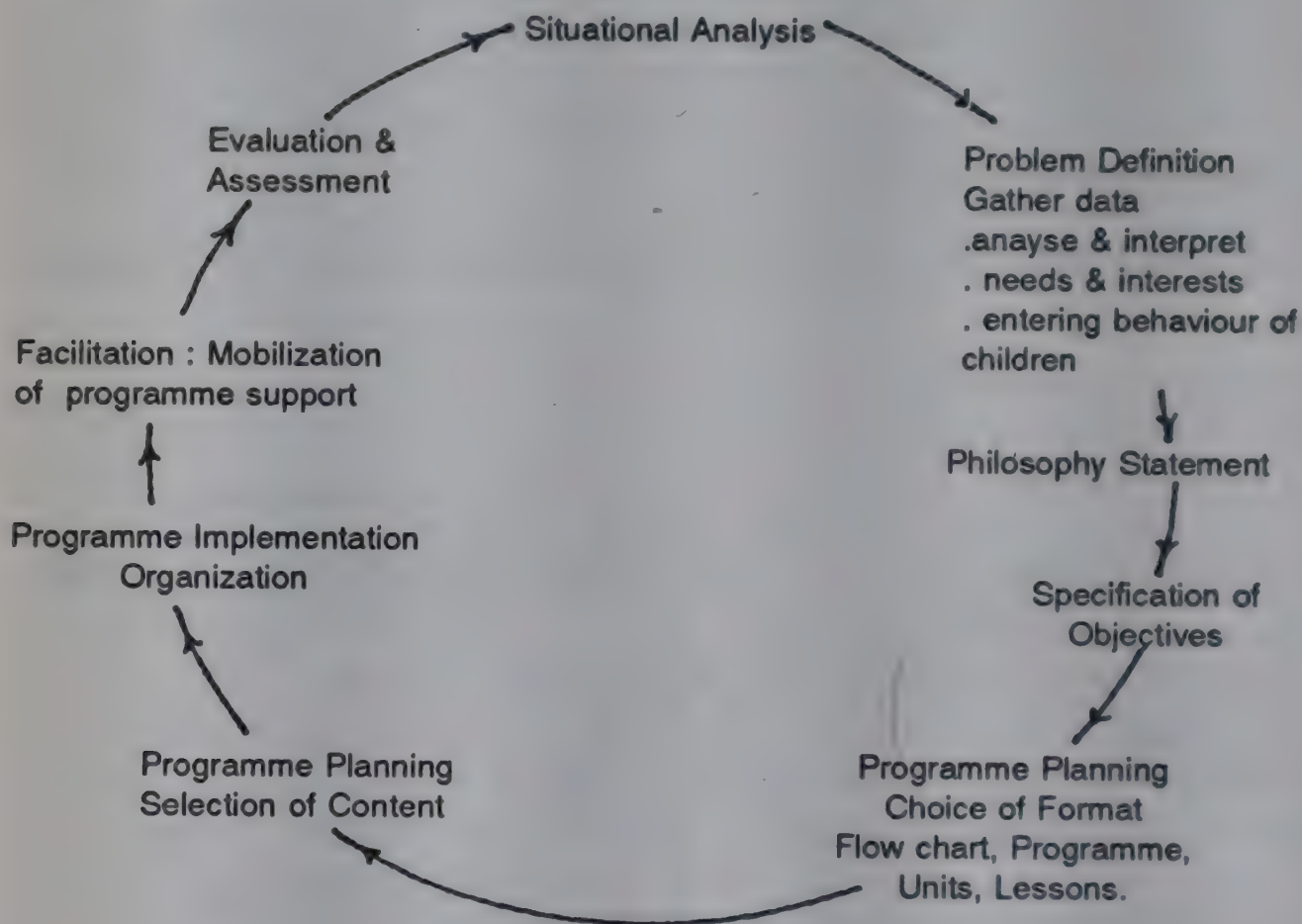


Fig III: DEVELOPMENT CYCLE

- C.L.Yarham (1980)

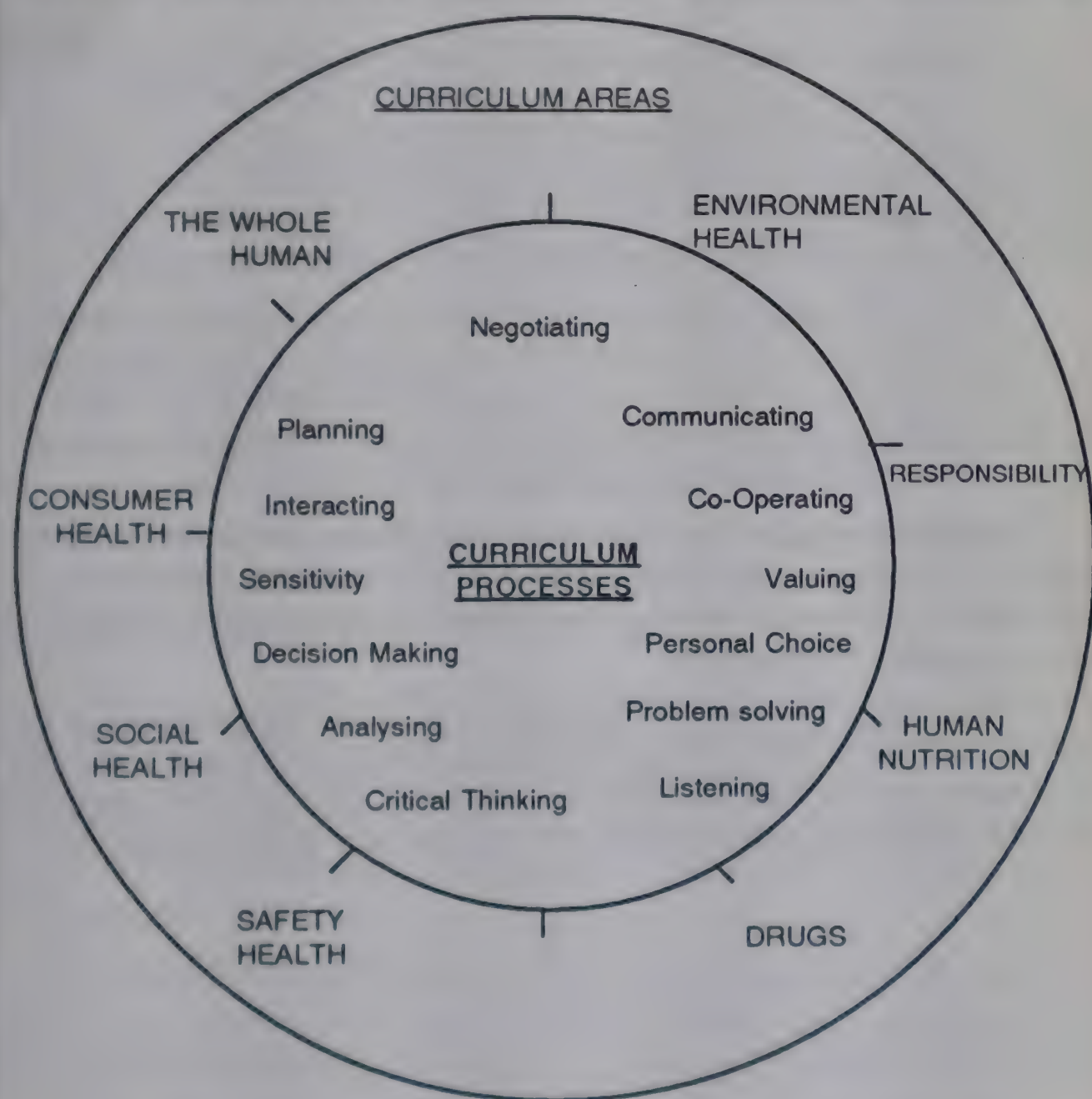
- Situational analysis involves the collection, organization and appraisal of essential data.
- In problem definition, following analysis and interpretation of the needs and interests of children, a clear picture of the scope of the program may be drawn.
- A philosophy statement which encapsulates the background approach to be adopted is a necessity.
- In specifying objectives targets should be clear and ends measurable.
- The detailed program planning requires well-considered strategies to provide environments supportive of change.



- The back-up required in program facilitation and implementation necessitates careful consideration of resources and widespread involvement of the whole school.
- Both evaluation of the total program and on-going monitoring of each phase will permit re-orientation and renewal of efficient effort in reacting to emerging needs.

## 6. THE CURRICULUM

In developing the curriculum emphasis should be given to processes which are essential to the health area. Education is a cultural action for freedom where "authentic dialogue between educators and



A Health Education, Health Promoton, personal Development,  
Life Skills, Living Skills Course.



learners" may occur. It must be a mutual process. (Freire, 1970) The methodology of Life Skills/Living Skills/Personal Development involving analysing, listening, critical thinking, communicating, interacting, decision making, planning, negotiating, problem solving and valuing, applied to each area of the curriculum are an inherent part of the part of curriculum and must be purposefully utilized in units of work and lessons at every opportunity.

Balance in teaching programs is a requisite. An ongoing week-by-week program approach is necessary through all grades. Too often in the past crisis-oriented approaches have been evident, with effort and funding slipping from one crisis issue to the next. It just doesn't work!

The eight content areas noted in Table II illustrate the breadth of matter required to provide a balanced school health education program. Look closely at the elements of this content, which are not meant to be exhaustive, but rather to serve as a general guide. The regional curriculum developed should address each of these areas of curriculum in a spiral curriculum approach through each of the grades.

General guidelines on teaching methods, techniques and suitable teaching aids should be included in the curriculum guidelines, with special reference to flexibility and adaptability in meeting the needs of local conditions and circumstances. Much emphasis should be placed on methods which emphasize attitude and behaviour change.

Emphasis should also be placed on guidelines for development of skills in teachers in communicating with parents and community, in establishing intersectoral support and developing functional collaboration in support of programs.

The ideas, attitudes, knowledge and skills encountered in an action-oriented curriculum such as this could well lead to the first steps in obtaining commitment to health in teachers, pupils and their parents. The cost-effective achievement of all of this is a prime objective.



**Table II**

## **HEALTH EDUCATION**

### **A HEALTH, LIFE SKILLS, PERSONAL DEVELOPMENT COURSE**

#### **AREAS OF THE CURRICULUM**

It is noted that there are eight areas designated in a balanced programme with continuity of topics from grade to grade. Emphasis should be placed on health and the promotion of a physical, social, emotional and economic environment conducive to health. This is not meant to be an exhaustive list of topics, but rather examples of possible topics in each area which may be utilized and adapted to meet local needs.

#### **PROCESSES OF CURRICULUM**

In dealing with each area of curriculum, it is important that the teaching encompasses processes essential to the health area which will empower students with skill in analysing, critical thinking, listening, communicating, interacting, decision making, planning, negotiating, problem solving, valuing.

##### **1. THE WHOLE HUMAN**

Genetic inheritance, growth and development, health and disability. Structure, function, care. Health and the ages of man. Physical, social, mental, intellectual, spiritual health & development throughout life. Managing life circumstances.

##### **2. RESPONSIBILITY AND HEALTH**

Personal health responsibility; rights and responsibilities. self maintenance, personal health care, physical maintenance, physical activity exercise and rest, risk factors of lifestyle, behaviour change, emotional self-help, self esteem, managing stress, goal setting, assertiveness decision-making, independence, individual difference, work/job satisfaction, leisure.

Community responsibility; Community Health, concept of community, community expectations and decisions-making, social behaviour, mental health. Responsibility in groups, school and community.



### **3. SOCIAL HEALTH (RELATIONSHIP)**

Human interaction, relationship and self; developing and maintaining relationships, privacy, tolerance, prejudice, group behaviour, group identity, peer group, family life, sexuality, family planning, loss & grief, death & dying. Changing relationships throughout life. Career pathways. Social and cultural factors. Conflict resolution and negotiation.

### **4. SAFETY HEALTH**

Understanding challenge and risk. Risk taking behaviour and consequences. Causal factors, protective behaviour, survival skills. Violent injuries. Violence in today's world. Human safety-Home, occupational, community, recreational, public safety. Trauma, from abrasion to paraplegia. First aid. Community health and stress reduction.

### **5. ENVIRONMENTAL HEALTH**

The world environment and health. Maintenance of natural environment. Safe water and waste disposal. The living environment-domestic, work, recreational, educational, commuting. Health promotion in the workplace-Occupational health, rural & industrial. States of health and disease; infectious disease, preventive measures, early diagnosis, dealing with sickness. Regional problems and disease control. AIDS/STDs.

### **6. NUTRITION AND HEALTH**

Diet, choice of foods, balanced eating, dietary needs and practices; social, economic, ethnic, cultural, religious, political and technological factors, deficiency and abundance diseases. Breast feeding. Food growing, cooking, storage. Commercial foods, school foods.

### **7. DRUGS**

Mood and behaviour modifying substances. Emotional health.alcohol, tobacco, hard drugs. Medical use, overuse, misuse of drugs. Drug education.

### **8. CONSUMER HEALTH**

Provision and availability of health care, Equity and priority. Health care delivery,use and overuse. Village, local, district, state, national, regional, W.H.O. health services, Health goods & services. Consumer problems, choice and needs. Ethical & moral factors. Historical factors. Traditional and local medicine practices, Alternative medicine.



## RECOMMENDATIONS

The intersectoral and multifactorial nature of influences on health behaviour of young people and adults are well appreciated by us, and we believe that justice can be done to promotion of health only when every one plays their role fairly and effectively. Therefore, the suggestions here are in no way exhaustive.

Not with standing, there are a number of areas where we feel some immediate action could be taken within the present framework, without serious constraints:

1. The training of teachers would be improved by having a nutrition and health education tutor in all the teacher's training colleges.
2. The syllabus followed by teacher trainees should include nutrition and health education either as a separate topic or as a distinct subject within Science.
3. The Ministry of Education should give serious consideration to making nutrition and health education a separately taught, time-tabled and examination subject in the primary school curriculum. Alternatively, the health education lessons could be consolidated into discrete blocks within the Environmental Science syllabus.
4. Implementation of (3) would require appointing a senior curriculum specialist in nutrition and health education at the Centre for Curriculum Development, as well as an Inspector of Schools for health education. Even if it is decided not to make health education a separate topic in the curriculum, a curriculum specialist in health education should be on hand to foster and improve the current intergrated approach to health education teaching.
5. Better liason between the Ministries of Education and Health and the national Food and Nutrition Commision is needed to improve the teaching of nutrition and health education. Specifically:
  - (a) Health education tutors in the Ministry of Health should develop more systematic programmes in the schools (e.g. advising schools on how to make or obtain visual aids and health-related instructional materials, how to utilise local clinic resources, etc.)



- (b) Public health nurses and other medical personnel, in association with the heads of local schools, should be encouraged to arrange in-school discussions on health/nutrition issues for primary teachers on a regular basis (e.g. Once a term). These discussions should focus on current health or nutritional issues which affect pupils and on improving teachers' understanding of topics in the primary syllabus.
- (c) The two ministries should organise more health education workshops for practising teachers.
- (d) Provision and distribution of teaching materials and visual aids should be facilitated. These would include the development of reference pamphlets on particular health topics for teachers' use, development of more visual aids for classroom teaching, and distribution of the NECZAM booklet *How to Keep Healthy*, to Grade 7 pupils (not just schools, as is currently the case).

In developing visual aids, existing resources at the visual aids centres (Chalimbana Teachers Training College, Chainama College, Family Health Programme, and Centre of Curriculum Development) should be better utilised.

- 6. The task-oriented approach in health education teaching should be employed more frequently and should involve the school (teacher), pupils, and the adults with whom they live. Assignment in health education should take creativity, innovation and seasonal relevance into account. Outreach of schools into homes and local communities should be a regular part of school activities and not carried out just during Humanism Week.
- 7. Primary Schools should be encouraged to arrange special nutrition and health education sessions for parents, under the auspices of the PTA, with the assistance of local clinic personnel.
- 8. UNICEF, UNESCO and/or WHO should be approached to assist with funding of workshops, visual aid development, and provision of instructional materials.
- 9. Better distribution of already available local resources should be emphasized.



## REFERENCES

- Freire P. (1971) Unusual Ideas About Education International Commision on the Development of Education Paris UNESCO.
- Grant J.P. (1991) Opning Address to the XIV World Conference on Health Education Helsinki UNICEF.
- Hallak J. (1990) Investing in the Future Paris UNESCO/Pergamon Press.
- I.U.H.E. (1987) Policy Statement on Health Education for the School-Age Child Paris I.U.H.E.
- Kolubine V.(1991) Addres XIV World Conference on Health Education Paris UNESCO.
- Keller B.B. & Mwambazi W.C. (1983) Health Education in the Primary School Curriculum and Knowledge Transfer from school to Home, Malaria and Child-Feeding in Urban Zambia, Zambia Ministry of Health.
- UNICEF, WHO, UNESCO (1990) Facts for Life Benson P.L.A.
- UNICEF (1990) The State of the World's Children N.Y. UNICEF
- W.H.O./UNICEF (1986) Helping a billion Children Learn About Health Geneva W.H.O.
- WHO (EMRO) UNICEF ( 1988) Prototype-Action-Oriented School Health Curriculum for Primary schools, Alexandria WHO.
- W.H.O. (1989) Health Promotion in Developing Countries, Geneva W.H.O.
- W.H.O. (1990a) Prevention in Childhood and Youth of Adult Cardiovascular Diseases: Time for Action General W.H.O.
- W.H.O. (1990B) The Health of Youth, Technical Dicussions Report Geneva W.H.O.
- W.H.O.(1990c) Guide to Planning School Health Programmes for Preventation of AIDS & STDs, Geneva W.H.O.
- WHO/IUHE (1991) Meeting Global Health Challenges: A Position Paper on Health Education, Helsiniki IUHE.
- WHO/UNESCO/UNICEF (1992) Coprehensive School Health Education, Geneva WHO



Yarham C. (1980) Effective Lifestyle, Sydney K.C.A.E.

Yarham C. (1987) Health Education for the School-Age Child, Editorial HYGIE, International Journal of Health Education, Paris IX 1987/3

Yarham C. (1988) Foreword in D. Tamir Health Education in Schools, Freund.

Yarham C. (1989) An Involvement Model, in SEARB Bulletin III,2,4 Bangalore SEARB/IUHE.

Yarham C. (199) Health Education Promotion: Communication and Youth, Editorial HYGIE, International Journal of Health Education paris IX 1990/2.



# PEOPLE'S INVOLVEMENT IN PROGRAMMES AIMED AT HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN IN SOUTH EAST ASIA

*Dr. Saroj S. Jha*

I congratulate the organizers for selecting such an important topic as the theme of the conference. This clearly reflects the concern of the South East Asia Regional Bureau of the International Union of Health Promotion and Education to the health of a vast segment of the population in the Region, who by reason of their unique biological status and functions and impacted by a multitude of cultural and social factors remain the most vulnerable segment of the population, especially where health is concerned. A number of indicators point out the fact that women and children in the Region need very special attention.

**Table 1**  
**PROJECTED SEX RATIOS**  
**(MALES PER 100 FEMALES)**

Country	1980	1985	1990	1995	2000
Bangladesh	106.5	106.4	106.3	106.2	106.1
Bhutan	106.0	106.7	107.2	107.5	107.6
DPR Korea	96.6	95.3	96.1	97.0	97.7
India	107.4	107.2	107.0	106.7	106.4
Indonesia	98.9	99.1	99.3	99.4	99.5
Maldives <sup>2</sup>	...	...	106.0	...	...
Mongolia	100.5	101.0	101.4	101.8	102.0
Myanmar	100.3	98.7	99.0	99.3	99.5
Nepal	104.7	105.1	105.4	105.7	105.8
Sri Lanka	104.0	102.1	100.7	99.5	98.7
Thailand	100.6	100.7	100.7	100.7	100.7
SEAR	105.2	105.1	105.0	104.8	104.7

Sources: 1.UN, World population Prospects 1990.

2.Statistical Yearbook of Maldives, 1990.

*Dr. Saroj S. Jha, Ag. Regional Advisor Health Education  
WHO/SEARO, New Delhi.*



The overall sex ratio of a population, as you are aware, is the result of complex interaction of many factors which includes the sex ratio at birth and the past history of gender differentials in mortality and fertility levels.

The sex ratio for the South East Asia Region as a whole is estimated by WHO to be 105 males per 100 females in 1990 which is higher than the world Figure of 101.4. Five countries of the Region namely Bangladesh, Bhutan, India, Maldives and Nepal have sex ratios above that of the world. The projection for the year 2000 do not show improvements.

**Table 2**  
**Life expectancy at Birth (in Years), 1990**

Country	Male	Female	Both
Bangladesh	56.4	55.4	55.8
Bhutan	48.8	47.3	...
DPR Korea	70.9	77.3	74.3
India	58.1	59.1	58.6
Indonesia	61.0	66.7	...
Maldives <sup>a</sup>	...	...	64.0
Mongolia <sup>a</sup>	...	...	63.1
Myanmar	57.6	62.0	60.0
Nepal	55.4	52.6	54.0
Sri Lanka <sup>b</sup>	67.8	71.7	...
Thailand	61.8	67.5	....

<sup>a</sup>For 1984    <sup>b</sup>For 1981

Source: Country reports of the second evaluation of the HFA strategies (CFE/2).

Life expectancy at birth, another important indicator, continues to be lower for females in Bangladesh, Bhutan and Nepal.



Table 3

# MATERNAL MORTALITY RATES PER 100, 000 LIVE BIRTHS FOR SEAR COUNTRIES

Country	1980 <sup>1</sup>	1980-88 <sup>2</sup>	1983 <sup>3</sup>	1985 <sup>3</sup>	1988 <sup>3</sup>	1991 <sup>3</sup>
Bangladesh	600	600	...	...	...	480
Bhutan	...	1710	...	770	...	...
DPR KOREA	...	41	...	...	...	...
India	500	340	...	300-400	...	...
Indonesia	800	450	...	...	450	...
Maldives	...	...	...	...	...	300
Mongolia	140	100	...	...	...	...
Myanmar	140	140	...	...	50	90
Nepal	...	830	850	850	850	1500-2000
Sri lanka	90	60	60	50	60	...
Thailand	270	50	...	...	40	20

Sources: 1. World Bank, World Development Report 1991.

2. UNICEF, The State of the World's Children 1991.

3. Review of second evaluation of regional strategies for HFA, SEA/RC44/14.

Who estimates that every year about half a million women die prematurely due to abortion, complications of pregnancy and child birth. South East Asia accounts for a large number of these deaths. Although the statistics presented in the above table may not reflect the real situation due to fragmented and incomplete data, it still points out to the wide disparity that exists in this part of the world where maternal mortality rates are almost 50 times the average of the developed world.



Table 4

# Immunization Coverage (%) of Infants and Pregnant Women in SEAR Countries

country	year	Infants					Pregnant women	
		BCG %	DPT %	OPV %	MEASLES %	Surviving infants (in thousands)	TT2 or booster %	Estimated eligible target (in thousand)
Bangladesh	1987	14	9	8	6	4 145	7	4 631
	1990	86	69	69	65	3 769	74	3 343
Bhutan	1987	38	27	27	23	49	10	57
	1990	98	95	95	89	22	63	15
DPR Korea	1987	69	62	70	35	634	0	652
	1990	99	98	99	98	632	...	...
India	1987	46	58	50	17	22 133	47	24 758
	1990	97	92	93	87	23 800	77	19 450
Indonesia	1987	68	48	45	46	5 048	27	4 463
	1990	93	87	91	86	5 029	54	2 993
Maldives	1987	59	6	6	9	9	2	9
	1990	99	94	94	89	9	92	7
Mongolia	1987	60	79	80	61	68	0	72
	1990	90	83	85	85	73	...	...
Myanmar	1987	45	23	13	14	1 168	24	1 225
	1990	95	88	88	63	1 095	80	621
Nepal	1987	78	46	40	...	634	15	731
	1990	92	75	74	64	709	27	1 044
Sri Lanka	1987	61	61	62	47	452	39	466
	1990	88	90	90	83	346	60	198
Thailand	1987	61	48	47	35	1 441	38	1 504
	1990	99	92	92	80	881	77	675

Note: BCG- tuberculosis immunization. MSL-measles immunization. TT2-tetanus toxoid second dose.

DPT- diphtheria, pertussis and tetanus vaccine (three doses).

OPV-oral polio vaccine (three doses).

Sources: 1. WHO/SEARO, 40th Annual Report of the Regional Director 1988.

2. WHO/SEARO, EPI Overview in the South-East Asia Region 1991, EPI/GAG/ 91/WP.6.

Even though TT coverage of Pregnant Women has improved considerably in the years between 1987 and 1990, the average was about 70% in July of 1991. All countries of the South East Asia region are committed to achieve and maintain atleast 90% immunization coverage by the Year 2000.



The child immunization coverage for South East Asia Region in 1990 was estimated at 86% for DPT 3 vaccine, 87% for OPV 3, 80% for measles, and 95% for BCG.

Infant mortality rates are high in many countries of the Region.

**Table 5**

**Infant Mortality Rates per 1,000 Live Births as Reported by SEAR Countries**

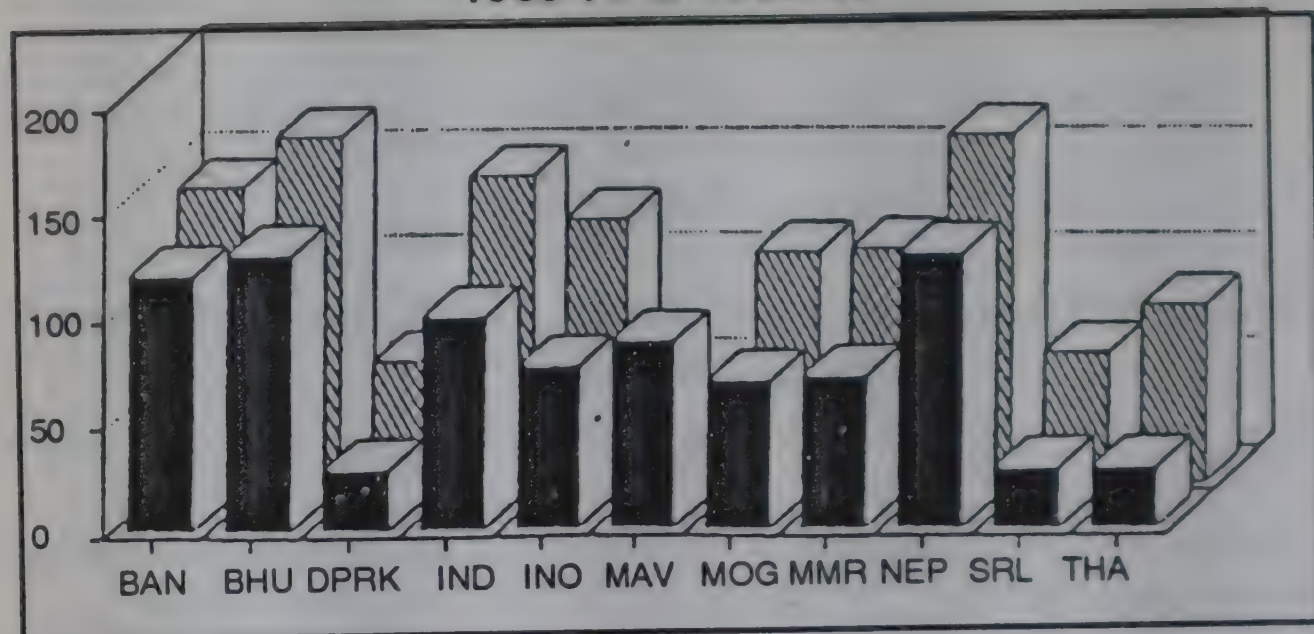
Country	1983 (1980-82)	1985 (1983-85)	1988 (1986-87)	1990 (1988-90)
Bangladesh	122.0	116.3	...	94.4
Bhutan	..	142.0	...	...
DPR Korea	11.4	10.0	9.8	...
India	114.0	97.0	94.0	96.0
Indonesia	98.0	71.0	50.0	58.0
Maldives	77.0	71.0	58.0	43.0
Mongolia	...	...	65.0	60.9
Myanmar	71.4	31.3	41.5	44.3
Nepal	152.0	...	107.0	105.3
Sri Lanka	30.5	24.2	24.0	19.4
Thailand	...	45.3	38.0	...

Source: Review of the second evaluation of regional strategies for HFA, SEA/RC44/14.

Although infant mortality are high, significant achievements have taken place over the last 25 years.



## Infant Mortality Rates in SEAR Countries 1965-70 & 1985-90



1985 - 90
  1965 - 70

Under five mortality rates are also high.

**Table 6**  
**Under-Five Mortality Rates per 1,000 Live Births  
Reported by SEAR Countries**

Country	1983	1985	1988	1990
Bangladesh	...	...	...	161/125 <sup>a</sup>
India	193	160	...	142
Indonesia	...	...	117	111
Myanmar	...	...	120	...
Nepal	222	...	200	196
Sri Lanka	...	...	43	...
Thailand	65	58	51	46

<sup>a</sup>Rural/Urban.

Source: Review of second evaluation of regional strategies for HFA, SEA/RC44/14.

Mortality differentials between males and females are significant. In four of the nine countries with available information i.e. in Bangladesh, Bhutan, India and Nepal, the under-five mortality rates for females are higher than those for males. (Table 7)



**Table 7**

**Under-Five Mortality Rates per 1,000 Live Births by Gender for SEAR Countries, 1989**

Country	Male	Female
Bangladesh	146	162
Bhutan	180	187
India	118	134
Indonesia	95	80
Mongolia	94	79
Myanmar	98	82
Nepal	178	187
Sri Lanka	28	22
Thailand	39	29

Source: World Bank, World Development Report 1991.

**Table 8**

**Coverage of Maternal and Child Health Services by Trained Personnel for SEAR Countries**

Country	year	percentage of live births covered		
		pregnancies	Deliveries	Infants
Bangladesh	1988	12.0	5.0	...
	1990	39.4	6.9	...
Bhutan	1985	3.4	3.4	...
	1988	16.0	7.0	38.0
	1990	7.0	16.0	51.0
DPR Korea	1985	100.0	100.0	100.0
	1988	100.0	100.0	100.0
	1990	100.0	100.0	100.0
India	1985	45.0	32.5	
	1988	40.0	32.0	25.0
	1990	70.0	75.0*	80.0
Indonesia	1988	56.7	40.7	55.6
	1990	46.6	43-50	62.3
Maldives	1985	47.0	...	...
	1990	50-60	50-60	100.0



Mongolia	1985	...	99.6	...
	1988	96.9	99.8	99.1
	1990	98.4	99.9	99.6
Myanmar	1983	90.9	97.4	...
	1985	75.0	25.0	71.0
	1988	87.3	92.8	...
	1990	90.1	94.0	...
Nepal	1985	17.0	10.0	10.0
	1988	9.4 <sup>b</sup>	5.6 <sup>b</sup>	...
Sri Lanka	1983	68.5	...	62.3
	1985	...	86.9	...
	1988	81.6	83.5	82.2
	1990	86.3	85.2	87.5
Thailand	1985	67.8	59.1	96.3
	1988	78.3	82.0	98.6
	1990	53.4	70.8	37.5

<sup>a</sup>Estimated value.    <sup>b</sup>From study data.

Source: Review of second evaluation of regional strategies for HFA, SER/Re44/14.

Coverage of MCH services by trained personnel shows low coverage in several countries.

## WOMEN, HEALTH AND DEVELOPMENT

Improvement of women's health and their participation in the development process have been the subjects of several world health assembly (WHA) and Regional Committee (RC) resolutions.

As already noted, female life expectancy at birth has increased in the last five years in all SEAR countries, quite substantially in some. However, the life expectancy for females is still lower than that for males in Bangladesh, Bhutan and Nepal. Sex differentials in infant, under-five and adult mortality have narrowed, but in the Indian subcontinent the improvement in female mortality in general was not commensurate with these changes.

Total fertility rates in the Region have generally declined, but a very large number of women still carry out the basic function of child-bearing without much support, such as antenatal care and assistance at delivery by trained personnel. In addition to malnutrition, the health of many women has been aggravated by early and repeated pregnancies. Female literacy rates and gross enrolment rates for females in primary schools, though improving significantly, are still behind those of males in several SEAR Countries.



The gains achieved so far, however, have not significantly changed the basic picture for many women in the Region. Their environment remains affected by cultural gender biases and the pressures of poverty. Countries still need to accord high priority to strategies to facilitate equal participation of women in the development process.

A women Health Development Initiative in the S.E. Asia Regional Office of WHO has seen an intensified effort over the past 2 years to make women health and development issues visible in the Region and to incorporate such issues in the various WHO collaborative programmes in the Region. Following the technical discussions on women, Health and Development held during the fortyfifth World Health Assembly in 1992 a Global Commission on Women's Health has been established to provide a mechanism for advocating greater attention to and action for women's health.

Coming back to the theme of this conference, namely people's involvement in health and development of women and children programmes, let us recall for a brief moment a major affirmation, stated in the Alma Ata declaration which is of utmost relevance to the subject of this conference. It was affirmed that people not only have the right to participate individually and collectively in the planning and implementation of health care programmes but they also have a duty to do so. In emphasizing this, the importance of full and organized community participation and ultimate selfreliance with individuals, families and communities assuming more responsibility for their own health was recognized.

Ten years later at Riga, it was stated that "Involvement of Communities in PHC is not an ethical nicety. It is a technical and social necessity". It is now well recognized that science and technology have come to a point where their contribution to further improvement of health standards can make a real impact only if the people themselves become full partners in health protection and promotion. Over the past 10 Years or so, some fresh thinking on development practices has led to the emergence of the concept of community involvement in health. The term "involvement" is preferred to "participation" as it implies a deeper and more personal identification of members of the community with primary health care. It implies a partnership being established between individuals, community groups and organizations both government and non-government in planning, operation and control of health activities using local, national and other resources. From this flows "community action for health", an area of special interest to WHO.



In 1993, it was the subject of the technical discussion at the south East Asia Regional Committee and this year it will be the theme of the technical discussion at the 47th World Health Assembly.

It is worth looking at the recommendations made at the 46th session of the WHO Regional Committee of S.E. Asia. These are as follows:

- (1) Strengthening Community action for Health in National Health Policies.
- (2) Sensitization and Reorientation of the Health system.
- (3) Empowering the Community for Action.
- (4) Enhancing the Role of Women.
- (5) Ensuring Multisectoral Linkages for Health Development.
- (6) Facilitating Effective Collaboration with NGOS.
- (7) Mobilizing International Technical and Financial Assistance.

Community involvement in health is a long process which involves a thorough understanding of the community and its dynamics. To facilitate the process the following are crucial:

- CREATING POLITICAL WILL AND COMMITMENT
- DIALOGUING WITH COMMUNITIES ENDING WITH MUTUAL UNDERSTANDING
- MUTUAL TRUST AND CONFIDENCE, ENTHUSIASM AND MOTIVATION
- INFORMATION AND EDUCATION - generating demand; EMPOWERING
- IDENTIFYING CHALLENGES, BARRIERS AND CONSTRAINTS AND HOW TO OVERCOME THEM WITH THE COMMUNITY
- JOINTLY WITH COMMUNITY PLANNING AND DESIGNING THE PROGRAMME FOR MANAGEMENT, IMPLEMENTATION, MONITORING AND EVALUATION.
- PROVIDING BACK UP SERVICES, HEALTH, EDUCATION ETC.
- DOCUMENTING PROCESSES, SUCCESSES, FAILURES AND LESSONS LEARNT
- ENSURING (JOINTLY WITH COMMUNITY) SUSTAINABILITY
- WORKING INTERSECTORALLY. ALLIANCES BUILT WITH SOCIAL AND POLITICAL FORCES, PROFESSIONALS, PUBLIC, PRESS, PRIVATE SECTOR AND



VOLUNTARY ORGANIZATIONS OF ALL SECTORS  
ESP., WSS, AGRICULTURE, EDUCATION, LABOUR,  
WOMEN, YOUTH, MEDIA, SCHOOL TEACHERS.

-- PROMOTING WOMEN'S PARTICIPATION.

## RESEARCH

There are several benefits in such an approach:

- i) COST EFFECTIVE WAY OF EXTENDING A HEALTH CARE SYSTEM TO THE GEOGRAPHICAL AND SOCIAL PERIPHERY OF A COUNTRY
- ii) PROGRAMME BECOMES MORE EFFICIENT WITH GREATER COORDINATION OF RESOURCES, ACTIVITIES AND EFFORTS.
- iii) PROGRAMME BECOMES MORE EFFECTIVE.
- iv) PROMOTES EQUITY: SOLIDARITY, SHARING OF RESPONSIBILITY.
- v) PROMOTES SELF-RELIANCE AND INCREASES PEOPLE'S CONTROL OVER ISSUES.
- vi) PROMOTES SUSTAINABILITY.

The relevance of community involvement in health need to be looked at in the current socio-economic and political environment. The second evaluation of the HFA done in 1991 showed that there have been some notable gains in the health situation in the Region. The life expectancy has increased particularly in the females. The overall mortality has decreased but there are wide variations in a country. Significant variations still remain between countries in maternal mortality and under-five mortality and in care of infants and pregnant women. Sex differentials in mortality with an adverse rate for females is a feature in many of the countries of the region. In summary, even though there are improvements in the health situation, Women and children continue to bear the brunt. The status of women continues to be inferior; her educational status and her access to health information and health are low even though many attempts are being made to reverse the situation. Demographic changes with increase in population, changes in age structure and rapid urbanisation, changes in social values and life styles, more drug abuse, chronic diseases and threat from diseases like AIDS have increased the burden on the already overstretched health systems. The problems of the economically poor like malnutrition and infectious disease continues, though much less compared to a decade ago. Politically, decentralisation and emphasis on human rights are getting more focus. Economies in most countries is affected and resources for health are decreasing. Alternate mechanisms of financing health care has to be identified and the whole health



structure may have to be further reoriented to primary health care approach. A relook at the community's role and people's involvement is thus very critical.

The second evaluation of HFA related to community involvement showed that many countries in the Region have made attempts to involve community in health care programmes. In this Region, we have many examples of successful community actions for health which have led to increased awareness about health, improved health status resulting in overall socio economic development. Most of these efforts have been done in small scale, mostly in the NGO efforts country wide. There are few examples of efforts which have been successful countrywide. The organisers of this conference deserves credit for including the lessons learned from successful programmes of community action for health as one of the important topics for this conference. It is urgent that we look at the factors which determined the success of some of the programmes and see how they can be replicated/scaled up into national health systems. Before getting into discussions of various health programmes where people have been involved, it is important for us to look at some of the factors which within the health system and within the community may hinder the processes of community involvement.

CONSTRAINTS/OBSTACLES/BARRIERS TO COMMUNITY ACTION FOR  
HEALTH-FACTORS OPERATING WITHIN THE COMMUNITY.

"HEALTH" NOT PERCEIVED AS A PRIORITY FOR ACTION BY  
THE COMMUNITY

- APATHY
- DEPENDENCY
- LACK OF CREDIBILITY
- LOW STATUS OF WOMEN
- NOT HOMOGENOUS IN TERMS OF PRIORITIES, CONCERNS
- LOW LITERACY LEVELS
- NOT COMFORTABLE IN ACCEPTING RESPONSIBILITY FOR THEIR OWN HEALTH.
- POLITICAL PARTY ALIGNMENTS.

CONSTRAINTS/OBSTACLES/BARRIERS TO COMMUNITY  
ACTION FOR HEALTH-FACTORS OPERATING WITHIN  
HEALTH SECTOR

- CONCEPT IS NOT CLEAR



- HEALTH SERVICES TRADITIONALLY ARE IMPOSED-NOT PARTICIPATORY
- KNOWLEDGE ON SOCIO-CULTURAL BEHAVIOUR, COMMUNITY ORGANIZATION OR DYNAMICS OF COMMUNITY IS LACKING
- NOT ENOUGH RESEARCHED INFORMATION AVAILABLE ON COMMUNITY DYNAMICS
- COMMUNICATION SKILLS AND MATERIALS ARE LACKING-FOR PARTICIPATORY APPROACHES.
- LACK OF INSTITUTIONAL ARRANGEMENTS WHICH WILL SURE COLLABORATION BETWEEN VARIOUS SECTORS. E N
- HEALTH WORKERS DO NOT WORK INTERSECTORALLY \
- TAKES TIME AND TIME BOUND PROJECTS DO NOT HAVE SUCH TIME.

In the S.E. Asia Region we have some notable examples of community involvement in maternal and child health programmes.

## INDONESIA

Indonesia's exemplary performance in the field of family planning is, I am sure, known to most of you here. A total fertility rate of 5.6 in the nineteen sixties is estimated to have fallen by 40% today and the country expects to achieve its planned growth rate of 1.6 per cent by 1995. How did this happen? This happened through a gradual process of decentralization, massive information and education campaign, provision of services and most important of all with involvement of the community. Support for the family planning programme came right down from the president himself to the political leaders at all levels including the village headman.

### 1. THE FAMILY PLANNING MOVEMENT IN INDONESIA

Indonesia's family planning movement was first private sector based and then was being provided through the government clinics. In 1970, president Soeharto established the National Family planning Coordinating Board (BKKBN) which was to promote the 'small family norm' for the sake of health and well being of the family, community and the country. The Ministry of Health provided clinical services and the Ministry of Religious Affairs was consulted to ensure that the approaches were consistent with the religious beliefs and had the support of the religious leaders. The Ministry of Information and Broadcasting also supported the programme and the Ministry of Education included small family norm in their curricula. The Ministry of Industry encouraged employees to use family planning and, the



Home Ministry started monitoring local birth rates and family planning use.

## OUTREACH WORKERS

The next phase began in 1972 when the National Family Planning Coordinating Board developed a group of family field workers whose primary function was to motivate and provide family planning services. One worker covered 3-5,000 population. These workers worked out of the government clinics. In 1974, a critical decision was taken to move these workers out of the clinics and put them in the community. The family planning coverage increased, but it was discovered that as no new cases were being brought in, a new approach was needed.

## VILLAGE ACCEPTORS CLUB

Acceptors in the village enjoyed meeting to discuss their experiences, their commitment and their expectations. For a small stipend, community members were willing to distribute contraceptives to each participating household. This led to a Volunteer force and indigenous community organizations started a community based family planning club called acceptor clubs. There was no cost to BKKBN except for supply of contraceptives. These community based women acceptor groups took over the family planning programme and thus started the national movement of today. The club recruited new acceptors and encouraged the participation of their members. The records of acceptors were kept which gave the clubs a sense of being in charge and they contacted the health workers rather than the reverse for supplies. The community ownership led to commitment. The government on its part gave reliable, regular and free supplies and provided back up services. Because of the communities' involvement and demands, service delivery improvement became a major concern of the government. The BKKBN also developed a simple information system which helped to record details of the acceptors which was processed rapidly and a regular feedback was given to various levels including the village clubs. This helped the village leaders to be fully informed about the family planning status of the community. During monthly meetings of the hamlets, some communities even displayed maps showing contraceptive choices of each household. Village sign boards showed what percentage of the population were using contraceptives, promoting competition among villages. Villages with good family planning acceptance were recognised by civil leaders. Although no monetary incentives were provided, some communities did receive some facilities for credit



etc. By late 1970, Family Planning had become a people's movement.

## **BEYOND FAMILY PLANNING TO INCLUDE OTHER SERVICES**

The Family Planning Coordinating Board realised that just providing family planning services was not sufficient to promote a small and prosperous family. They identified the potential of village based child health and nutrition services for sustaining family planning efforts. Women Family welfare clinics (pKK) were in existence in almost every village and were the core of the acceptors clubs and were involved in weighing children. In 1979, the family planning nutrition programme (KB-Gizi) initially aimed at families of family planning acceptors, but later on included other families. The field workers were retrained for village based child health and nutrition activities and to assist the mother's groups in monthly child based nutrition activities. Re-supply of contraceptives was undertaken during the child nutrition activities. Bringing family Planning and child health together gave more meaning to the small and healthy family slogan. The programme was extended to far flung islands in the nineteen eighties. Realising the potential of the village based nutrition cum family planning services, the department of health decided to start the village integrated service delivery post called posyandu. The monthly gathering run by village volunteers was now joined by a health worker from a nearby health centre who in addition to the above mentioned services also provided other child and maternal health services.

Several evaluations done have shown that not only has there been a decrease in birth rate and infant mortality, but there also has been an increase in literacy and family income.

## **LESSONS LEARNT**

A lot of useful lessons have been learnt from the Indonesian experience, some of the most significant being that getting support from key community leaders, involving women's groups and community organizations, encouraging people to make choices regarding the contraceptives most appropriate for them and efforts made to give to the community a sense of ownership of the programme, all such approaches made to secure true community participation, has paid off.



## **2 P K K**

In view of adverse conditions affecting the health and socio-economic development of women in Indonesia, a women's movement the PKK, was initiated in central Java in 1967 and expanded into a nationwide movement in 1972. The aim of PKK is to improve the quality of life of families through recruitment of women volunteers and to participate in the national integrated cross-sectoral programme to intensify women's role in promoting family health and welfare. PKK is a movement whose volunteers motivate the community to work for its own needs. In the field of mother and child health, PKK has established a post in every village called posyandu or 'Integrated Community Health services post' which offers five basic services-immunization, nutrition, family planning, mch and diarrhoeal disease control. Health education, family planning services and information are also provided.

To reach as many families as possible, households are organized into units of ten under the leadership of a chairperson elected from among the families in this unit. The chairperson maintains vital records of pregnancies, births, immunizations etc. as well as identifies illiterates for non-formal education. In this way, whole communities participate in village development activities centred around women.

## **INDIA**

### **TAMIL NADU INTEGRATED NUTRITION PROJECT (TINP)**

-- a lesson in scaling up

In spite of advancements in the demographic scene with lower birth rate and infant mortality, Tamil Nadu was one of the States in India with maximum number of malnourished underfives. In fact malnutrition was considered the leading underlying cause of death among children under five years of age. Pregnant and lactating mothers and adolescent girls formed the other groups deficient in calories. In the late 1970s, despite the government spending large amount of money on nutrition programmes only a small fraction of the target groups were reached.

The TINP Programme was started in the early 80s with assistance from the World Bank. A pilot project was undertaken in one district before it was expanded to 22 other districts. The focus of the project is to improve the nutrition and health of children under three years, pregnant and lactating women.

A community nutrition centre (CNC) was opened in every village with a community nutrition worker (CNW) and a helper. They are responsible for growth monitoring, selection of children for feeding and



for organising people to participate in health activities through demonstrations, house visits and organising women's groups. The CNW is a local woman, a mother of a healthy child. During selection, special emphasis was given to her leadership potential, communication skills and acceptability by the community. 10 CNCs are supervised by a supervisor who in turn is supervised by an instructor at the block level.

## **ACTIVITIES OF THE PROJECT INCLUDED**

(a) Growth monitoring and supplementary nutrition, supplementary nutrition being limited to only 'at risk' children identified by the criteria laid by the project. Pregnant women selected on the basis of the criteria laid down by the project were fed during the last three months of pregnancy and lactating women selected for feeding were fed for first four months after child birth. Some of the village women's groups set up projects for production of low cost weaning foods contributing to the income of local women. Women were organised under a co-operative society.

(b) Health care - The existing health system in the project area was strengthened to support health care of mothers and children.

(c) Communications were designed to familiarise families with and involve them in project goals, encourage them to accept services and influence them to promote activities which improve the health and nutrition of young mothers and children. Mass media and interpersonal communication techniques were used. Villages were prepared to receive the project by explaining the objectives and the design of the project.

A great emphasis was laid on the communication skills of the CNW. A key to community support was the Women's Working Group (WWG). 15-20 women identified by the CNW were gathered once a month to teach them about low cost nutritious recipes. Another innovation was the children's working groups who were taught to relay project messages through poems' songs and skits. During the monthly weighing sessions, growth of the child was discussed in detail with the mother and she was told what remedial actions should be taken.

(d) Management systems and evaluation. The project had a monitoring system which helped project managers. A mid term evaluation showed an impressive improvement in nutritional status, severe malnutrition was reduced by 25-55% . The project has shown how a large scale project with a complex design including growth monitoring, supplementary feeding, nutrition education and health interventions



can be done successfully with the help of community based nutrition workers. The cost effectiveness of the project is another important aspect.

## **LESSONS LEARNT**

Some of the key factors for success were the following:

- (i) use of community based workers from the community, their selection and training;
- (ii) communications with the community about the project to get their support;
- (iii) organisation of women's groups who motivated mothers to utilize the services, educated the mothers about importance of weaning foods and how to make them;
- (iv) self sufficiency of the community through organising their own weighing programmes and by producing low cost weaning foods;
- (v) sharing of information which has led to mother's involvement and convincing mothers of the advantage of growth monitoring.

## **BANGLADESH**

### **YOUNG VOLUNTEERS FOR HEALTH IN BANGLADESH**

The national youth organisation of Bangladesh (JTS) has several branches all over the country and supports government programmes from village to central level. The focus is mainly on motherhood, nutrition, child survival and family planning. At the grass root, the JTS involves youth in agriculture, fisheries, literacy, sports and income generating activities. The JTS also focuses on young people of school going age in and out of school and gives them education on nutrition, hygiene, delaying the age at marriage etc. Sporting activities and organizing other cultural activities and health and family planning campaigns are some of their other activities. The JTS works very closely with the religious leaders for all these activities for their support, and health promoting activities.

## **LESSONS LEARNT**

A useful lesson learnt from this project is that there is wide scope to harness the energy and enthusiasm of youth in health and development projects. They have an effective outreach especially for peer education and mobilizing other youth to participate in national health programmes.



## **NEPAL**

### **MOTHER'S CLUBS IN NEPAL**

Started by Ministry of Health in collaboration with the National Women's Organization mother's clubs are organized to reach mothers using female community health volunteers with back up from a health educator. The clubs address the various developmental needs of communities, rather than to any donor formulated targets.

### **INVOLVEMENT OF PEOPLE THROUGH THE NGO SECTOR**

#### **BRAC**

The Bangladesh Rural Advancement Committee (BRAC) was born in 1972 as a small charitable organisation to help reconstruct Bangladesh after the upheavels in 1971. By 1991, it has grown to be one of the largest indigenous NGOs in the world. The organisation's primary principle is a belief in people's ability to learn and manage their own affairs given the opportunity, methodology and skill to understand their particular circumstances in the larger setting. Thus BRAC helps people to understand their own situations and develop a framework for action which rejects fatalism and seeks self help. BRAC believes that people can be self reliant if empowered to understand their circumstances and supported by others in their own group.

BRAC started its health activities in one Thana as a part of its development activities. Started with curative clinic based approaches with doctors, it later shifted the responsibility to locally recruited and trained paramedicals who were allowed to charge a small fee. BRAC'S experiment with an insurance scheme in which households prepaid with 5 kgs of paddy failed as families were from lower economic strata and did not join the scheme as they did not understand the need to invest in future health. Efforts to allow the paramedics to charge a fee for service ran into trouble as few went into private practice and started treating illnesses beyond their capability. In 1977, the shashthya shebikas who are women chosen from the landless were recruited to take care of the health needs of the landless only. They were supplied with medicines and contraceptives and were allowed to charge a small fee. These women were accountable to the communities they served. BRAC got involved with the nationwide ORT programme in 1979 by teaching mothers to make salt sugar solution for diarrhoea. This was done using trained female workers who went house to house to teach. This programme was scaled up to all the villages in the country in 1980. The women were paid according to performance based on the number of women who knew how to mix correctly. In spite of scaling up, the



quality was maintained. To involve the male members of the family, male teachers were involved. This has led to a major revolution-people accepting ORS as the treatment for diarrhoea and knowing how to make it correctly.

In 1986 the child survival programme was started which essentially helped the government to improve its reach and quality by training government officials and also in mobilising communities to use the immunisation services and to demand sustained immunisation services. The primary Health Care Programme which was a subset to the child survival programme focussed on nutrition and health education, growth monitoring, training of TBAs and family planning. Again the main focus was on being facilitators for the utilisation of the government services. Tuberculosis treatment was added to this programme.

In 1990, BRAC restructured its health programmes to integrate it with rural development and nonformal education programme and called it the women's health and development project. The focus is on reduction of maternal and infant mortality. The long term goals includes literacy, income generation etc. Adolescent girls are trained for 2 years to serve as the village health cadre; a written undertaking is taken from the parents that the girls will not be married till she reaches 18. The girls will help with the government's health posts too.

## **LESSONS LEARNT**

Basic principles of BRAC are the beliefs that people can be taught self help and self reliance. The ORT programme was a good example of this. BRAC also showed that it is possible to replicate some programme such as the ORT and shashthya shebilla programmes.

## **SOCIETY FOR RURAL UPLIFT THROUGH RURAL ACTION (SUTRA)**

SUTRA is located in Jagjit Nagar in Himachal Pradesh in India. Women in this area mainly do all the agricultural work in addition to domestic chores and fetching water from mountain springs.

SUTRA started as a service input agency providing fertilisers, running creches and clinics. Now the focus is on raising awareness and helping people to organise together for their needs and claim their rights. In 1978, SUTRA started its health activities by getting local people trained and starting curative care. The health workers treated minor ailments and referred serious cases to the government health centre. From 1979, SUTRA ran several camps for women educating them about health, sanitation, role of women in the society, farming



methods etc. As a follow up of these activities, mahila mandals (women's groups) were formed. Discussions with women led to identification of health problems, problems during childbirth and lack of knowledge about child care. In 1982, as a result of women's demands for better care during pregnancy and childbirth, a dais training programme was started. The idea was to train already existing TBAs not only in providing care to pregnant women in safe delivery practices, but also in becoming change agents. The mahila mandals supported this idea of developing local women as change agents and planned to train the women to be aware of the problems they faced (in the areas of water, domestic chores, agricultural work, nutrition etc.) and to organise themselves to improve. Income generation activities were taught for economic independence and for improving social status and building up confidence by undertaking self reliant activities. The TBAs were selected by the mahila mandals. After training, the dais were given responsibility for 3-12 villages. The ultimate aim was to work for women's developmental activities.

As the project developed, many more women who were not TBAs enrolled for training. Today SUTRA is involved with other aspects of women's health such as gynaecological problems. They have organised women in such a way that they are confident of dealing with government programme officials and demanding services, they deal with problems of alcoholism, rape etc. They also have started a training programme for adolescent girls. The mahila mandal movement has been set up in other districts too.

Some of the lessons learnt included that it is possible to start with a felt need and move on to wider social issues, building self esteem and self confidence and self sufficiency.

## **POPULATION AND COMMUNITY DEVELOPMENT ASSOCIATION (PDA)**

To promote Family Planning in Thailand, PDA used innovative approaches that resulted in widespread adoption of contraceptives as a consequence of increased social awareness. With a large force of village volunteers it has used a wide range of culturally adapted strategies, one of its services being the community based family planning services. This has grown into a network of local self help schemes reaching several thousand villages. To extend coverage and maintain high user rates, it has adopted a consumer oriented approach.



These are only a few notable examples of approaches, programmes and activities being carried out in the South-East Asia Region related to people's involvement in the health of mothers and children.

Some of the projects are government initiated while others are initiatives of non-government organizations. While every project is unique in its own way, some common features characterize their implementation. These are, leadership development among health care personnel and volunteers, increasing community awareness in both women and men on the problems of women and children and how they can be overcome, empowering the community for action and linking programmes with other development sectors such as education and social welfare.

One common thread seems to bind these endeavours and that is a strong involvement of the community in programmes perceived by them as being crucial to their development. And of all the programmes that have a direct bearing on the quality of life, it is undoubtedly those that reach out to women and children.

One success of this conference, I sincerely feel, would be if those amongst us today could incorporate in the programmes they are involved in some of the elements of people's participation and involvement and thereby add greater meaning and a deeper dimension to programmes aimed at the health and development of women and children.



# COMMUNITY PARTICIPATION IN THE MANAGEMENT OF ICDS PROJECTS

*Prof. B.N.Tandon, M.D.,FNA*

We had listed very noble goals for ICDS. From the beginning in 1975, it has been stated that ICDS must become a people's programme. It should not end up as a Government programme. I have lived and grown with ICDS. I am sorry to say that ICDS is firmly established as a Government programme. Probably our old way of working has prevailed and therefore there has been no special effort to establish ICDS as people's programme.

It is certain that as long as there will be lack of community participation in social sector programmes there will be doubt on the viability of the programme. Several examples of very successful programmes/institution having early end and collapse due to people's non-involvement can be cited. We can avoid failure if we commit a proportion of our 'inputs' to establish community participation in national programmes.

ICDS in all over the country has involved large number of voluntary workers with modest facility of honorarium. This includes around 25 thousand AWWs, 10,962 medical officers, and voluntary organisations such as Indian Council of Child Welfare and several others. Many of us feel, this is not really reflection of true people's participation. A more systematic approach with firm foundation is needed.

Mass communication, identification of selected groups and organisation, systematic interaction with flexible but a formal plan for community participation and close monitoring of the implementation of this specific activity are some of the essential steps necessary to achieve the goal of community participation.

Listen and/or see, and know then act. In other words community should get an opportunity to listen and/or see and know all the aspects of ICDS before it can be expected to participate in the programme. State has several methods of mass communication - Radio, television, newspapers, big festivals are some important ones.

---

*Prof. B.N. Tandon M.D. FNA, Chairman, Central Technical Committee, Integrated Child Development Services, West Block No. 1, Wing-3, 2nd Floor, Post Bag NO. 16, R.K. Puram, New Delhi-110066.*



All of them can be effectively used for information dissemination about child status and child development activities in Tamil Nadu and in our country. Instead of ad hoc, a well planned mass communication approach can indeed effectively sensitize the community and stimulate interaction with the Government for a planned community participation.

One of the good approach to success is to work through the potentially motivated groups and institutions. Local authorities should be able to identify and select 12-15 such organisations in the state. This should be done strictly on the merit and no other consideration. I will like to stress that it is a critical step for our movement towards the community participation.

Interaction with these selected groups must be well planned and properly executed. Without intention of hurting the feelings of any individual/organisation or Department, I want to stress that there is very little positive effort, based on principles of sociology, to develop a team relationship between the government and voluntary groups. Unless we honestly admit this shortcoming of our system, and sincerely commit to get over it, we will be unable to get active cooperation of voluntary agencies and without it, we can never achieve the goal of community participation in our national programmes. I do not think it is required to state the details, how the nodal department for ICDS should initiate actions to identify the groups/organisation and discuss with them the plan for community participation. The Chairman of the Indian Institute of Socio-Economic Studies, Director Social Welfare and State Coordinator ICDS can start the process without any delay.

The 'plan' of operation and organisation for community participation should be clearly spelt out and specific activities for the community towards ICDS implementation at the village should be stated. Organisation to facilitate and monitor the work of the community should be established. Simple activities of the community which can be listed may include (i) assistance in listing of the beneficiaries; (ii) assistance in selection of eligible beneficiaries; (iii) participation by rotation in the activities at the Anganwadi; (iv) promotion of work related to environmental and personal hygiene (v) monitoring of the regular and proper quantities of supplies at the anganwadi; (vi) facilitating the work and motivating the anganwadi worker; (vii) strengthening the anganwadi infrastructure; (viii) promoting health and nutrition education. The village level organisation to stimulate and monitor the community activity may include female member of panchayat, School Teacher,



AWW, TBA/VHG/MPFW/PHC MO through sectoral conferences should help the monitoring of the community participation in ICDS. The functional monitoring system of CTC should include community participation as one of the subjects at all the levels from periphery to the centre.

There is no document or conference which does not write or talk of community participation, yet there is very little of it on the ground. Let this conference decide to develop a model and implement it. Other states may be stimulated by the programme to start this important activity. It is the first step which is important in a long journey.



# LESSONS LEARNT FROM THE INNOVATIVE EXPERIENCES OF COMMUNITY PARTICIPATION IN INDIA AND THEIR APPLICATION TO PEOPLE'S INVOLVEMENT FOR HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN

*Dr Sudha Xirasagar and Dr. Ashok Sahni*

## I. INTRODUCTION

Women and children constitute a major vulnerable section of the population. Children under 15 years constitute 4% of the total population and together with women in the child bearing age group of 15-49 years of age, they constitute approximately 62.7% or nearly two thirds of the total population. The quality of human resources of the country, both at present and in the future depend on the health of women, and the resultant performance in their physical, social, cultural and emotional role as mothers, care-givers in the family, nutrition-planners and even as providers among the rural and urban poor. The quality of future citizens also depends on the present health status of growing children, which in turn depends on antenatal nutrition of the foetus through adequate maternal nutrition, birth weight of the infant, under-five child's nutritional status, as well as socio-cultural environment. These factors among female children in turn determine the health of the future mothers, and thus the health of women and health of children are mutually reinforcing.

In the words of Pandit Jawharlal Nehru, "the nation marches on the tiny feet of children". Yet, these two population sub-groups, being the least assertive in the power structure of the family, community and country at large, have traditionally been the most disadvantaged, experiencing the least trickle-down benefits of health and socio-economic development programmes. It is no wonder that two of the most sensitive indicators summarizing the total health of a society, its physical, social and economic health, are the infant mortality rate and maternal mortality rate.

---

*Dr. Sudha Xirasagar and Dr. Ashok Sahni*

*Indian Society of Health Administrators (ISHA), Bangalore.*



## **II. INDICATORS OF HEALTH OF WOMEN AND CHILDREN IN INDIA**

### **PRESENT STATUS**

Table 1 shows the present status of indicators of maternal and child health in India, compared with the goals for 2000.

The table shows that in terms of the most basic indicators, i.e. prevailing mortality rates among children and mothers, much remains to be achieved by the year 2000. In terms of activity indicators, under the immunization programme almost 70-85% of the targeted population of mothers and children have been covered. Besides, the goals spelt out in the National health policy, a closely related goal, that of the national education policy 1990, is universalization of primary education upto Grade VIII by 1995. It has been repeatedly documented that completion of primary education upto grade VIII or even upto Grade IV by females, is associated with lower infant mortality, lower under-five mortality, better utilization of antenatal and preventive health care services(4,9,11).

## **III. CAUSES OF UNFAVOURABLE MORTALITY LEVELS AMONG MOTHERS AND CHILDREN IN THE CONTEXT OF NATIONAL PROGRAMMES TARGETING THE CAUSES**

The major programmes currently in operation at the National level, to improve health of mothers and children, the premises on which the respective programmes are based, and the current level of efficiency of operation are shown in Table 2.

The table shows that considerable progress has taken place under the various programmes. Besides the large scale National programmes indicated in the Table, many other measures such as dais training, National goitre Control Programme etc., have been implemented, also targeting mother and child health. As a result of these programmes, tremendous gains in maternal and child health have been made. The Infant mortality rate has rapidly declined from about 120 in the early eighties to about 80 in 1990, evaluation studies have shown reduction in outbreaks and severity of measles, wide spread massive reduction in incidence of neonatal tetanus and prevalence of lameness in under-five children (2,5). In spite of these achievements, several stubborn aspects of the MCH scenario are a matter of concern. These issues are as follows:



1. In spite of high immunization coverage and considerable antenatal service coverage, infant mortality continues to rule at very high levels of 120 or more, in the 90 backward districts identified in the country, with crude birth rates above 39 per thousand i.e. almost one in every five districts in India. 90 out of 445 districts has an IMR of about 110-120, in fact 29 districts have an IMR above 140. Appendix I shows the list of the districts and the prevailing MCH indicators in these districts. (6).

2. Maternal mortality rate has not been impacted, and continues to rule at about 4 per 1000 births, in spite of one decade of emphasis on MCH by the Health Department and Women and Child Welfare Department. (2)

3. Following dilution of priority to the UIP and other MCH programmes (as also all other health and communicable diseases control programmes) with the advent of HIV - AIDS, and with the move to integrate UIP into other primary health care services, UNICEF has observed a sharp drop in tetanus toxoid coverage of antenatal mothers from about 55% in 1990 to below 40% in the first three years of the nineties, at the international level after having increased from 13% to 55% in the eighties (7). Thus a reversal of trend is being seen, an event which was feared by senior UIP officers even at the peak of success of the UIP. The question is how long can a vertical unipurpose programme, with such a high density of inputs of men money, vehicles, POL, management systems and materials, be sustained?.

4. While rapid reduction in IMR through UIP and other programme interventions could be achieved, from 120 to 80 within five to seven years, the next phase of reducing IMR from the present 80-85 to 60, and of reducing under-five mortality from the present rates of about 20 to 10, and particularly to tackle maternal mortality, will become progressively more difficult, a situation of diminishing returns, as seen in the next few paragraphs. Problems to be resolved to achieve these reductions, would require the Indian Community at large to participate actively, not as mere passive recipients of a series of vaccine injections, iron and folic acid tablets, of Vitamin A drops, but as active performers to change the traditional attitudes and practice involving women in the premarital, marital and maternal role.

5. In spite of moderate to high coverages of tetanus toxoid immunization of mothers at the doorstep, when the matter comes to a little more active-health seeking behavior such as, making two visits to the PHC/subcentre for antenatal check ups, the percentage is low.



Similarly while passive acceptance of iron and folic acid shows moderate to high coverage statistics, when it comes to regular consumption of tablets, it is low (2).

To understand the problems in depth, a review of causes of infant, toddler and maternal mortality is required.

a. Of total maternal deaths, 18.4% are caused by anemia, 8.1% by puerperal sepsis, 11.8% by illegal abortions mostly by quacks, 15.2% by toxemia of pregnancy, 23.7% by haemorrhage (ante-partum or post partum) and by other causes 21.8%. All these factors are indirectly related to high fertility and births too closely spaced, with the added factor of nutritionally poor intake.

b. Of total infant deaths, 30% are due to low birth weight, 10-15% due to malnutrition, and 25% due to acute respiratory infection (2). Low birth weight is again dependent on maternal factors, the major ones being, high fertility, too closely spaced births, maternal malnutrition and over-exertion in pregnancy, maternal anemia, very young mothers (below 18), and toxemia of pregnancy (2,4). Similarly infantile and toddler malnutrition, which tends to be more frequent and of higher severity among girl children (8), is rooted more in child care and cultural practice, rather than poverty per se. Any number of studies have shown that at same family level, the infant and under-five child mortality rate is much lower among children born to mothers who have completed primary school education, compared with illiterate mothers (3,8). Similarly there is a vast difference between pattern of availing antenatal care, safe delivery services and contraceptive services by educated mothers compared with illiterate mothers (10,11). Severity and morbidity due to acute respiratory infection among infants and toddlers, is related to indoor pollution from wood and other fossil fuel fires used, indoor tobacco smoking, atmospheric pollution by vehicles in urban areas and poor temperature control (10).

The above analysis of factors affecting maternal and child mortality rates show their intimate relationship to community attitudes and lifestyle. Unless the community is educated and involved fully in the health process, no further gains in the MCH scenario can be expected.

#### **IV. PROGRAM IMPLICATIONS OF THE CURRENT MATERNAL AND CHILD HEALTH SCENARIO**

The outstanding programme implications of the current maternal and child welfare scenario, thus emerge as follows;



i. At the present stage of health development in India, community participation in the process is critical, if any further gains in MCH are to be made, and impact required, even to sustain the current level of achievements, which have been made by vertical, intensive programmes, particularly in the context of shrinking budgets for health and welfare programmes.

ii. Intersectoral coordination to improve other parameters of quality of life, namely, housing, sanitation, electric lighting, improvement of women's and girl child status, is also equally critical, as evident from the factors implicated in maternal and child mortality described above. For effective convergence of multisectoral inputs into a community, on a scale large enough to make a health impact, community participation of a very high order is essential, as shown by the experience of the slum improvement Projects by voluntary Organizations, by the Slum improvement Projects of the Vishakapatnam and Hyderabad Municipal Corporation (12).

Keeping in view the critical need for community participation in health and related fields for improving health of women and children, the following sections summarize the major learnings on community participation, drawn from an extensive study of 19 innovative health and development projects, all over India, in different contexts, rural poor, urban slum, tribal, organized sector employees, health projects linked to co-operatives and hospital-based outreach projects.(12).

## **V. MODELS OF COMMUNITY PARTICIPATION**

Internationally, health administrators and planners have recognized four models of community participation in health and development. The four models represent progressively higher levels of community participation in the project/programme. In the ISHA study, all four models were observed in the projects, depending upon the local and Project leadership factors. The four models (levels) of community participation are as follows:

**MODEL..I:** The health agency (voluntary or government ) offered curative services which is a felt need of the community. Through this entry point, health education was introduced into the community, and thus, the community was persuaded to accept the preventive, promotive and family welfare services, essentially provided by the agency itself. Whenever, community cooperation was required, e.g. coverage for immunization, antenatal care or indoor insecticidal spray, it was not forthcoming.



At this level, though community participation is evident self-reliance is the least apparent. In all likelihood, if the agency terminate its activities in the area, primary health care would go back to the pre/project state.

MODEL-II: At the next higher level of community participation the agency started operating curative services for the community as an out reach service. Through satisfaction of this felt need of the community, and through health education of the community leaders, the agency drew the people's participation as follows. The agency offered to provide technical and organizational inputs (with or without inputs like drugs and equipment) to set up a health/medical center, on the condition that the community donated land, building labour or some equipment.

In this case, although the Community involvement is greater than the first mode, it would be noted that, mostly, this is the participation of few community leaders or a few affluent persons, rather than the entire community. The dependence on the external agency is still considerable, and most likely, if the agency withdraws, health care will more or less go back to the pre-project level. Besides, the few influential members of the community the have, who participate, are more likely to manipulate the Project to meet their own needs, rather than that of the under-privileged for whom the Project originally started. At this stage, the participation of the community is still marginal and transitory. The involvement of the people has little direct influence on the orientation and outcome of the health programme.

MODEL-III. At the third level, the community to some extent participates on a more wide-spread basis. This was most evident in the health cooperatives, wherein, due to a higher community awareness of the need for services, the community, on a continuing basis, funds the health programme. In this model services, mobilization the funds, administration and maintenance of health cooperative's activities, remains largely the responsibility of the agency, and therefore the community still depends upon the external agency for the continuation of primary health care. However, the level of health education inputs that has been put into the community to bring this level of involvement and cooperative spirit is also likely to mobilise the community to actively seek primary health care services through other sources, in case the agency withdraws from the area.

Some measure of self-reliance in health, has thus been built up in the community as a result of the agency's intervention.



**MODEL-IV:** At the next level, community participation in its fullest sense is realized i.e. participation in planning, implementation and evaluation of the health services, tailoring it to local needs, mostly relying on local resources, including the human resources required for primary health care. Briefly, the process involves the following steps.

- a. Training of community based catalytic agents by the health agency-the community worker could be either a paid multipurpose worker, or voluntary village health worker/guide.
- b. stimulated by the catalyst, the community identifies its problems and its felt needs.
- c. The formal and informal leaders are identified and utilized in determining priorities and working out ways and means to meet the needs, including finding local resources such as, the building to house the health post, equipment and manpower/
- d. Local initiative and local resources were developed and utilized to solve the problem.
- e. As the process continued the community become increasingly self reliant and gradually got involved in planning, implementing and evaluating the health services.

Thus in this model of structural participation, the village as a unit or a community was transformed from being a group of passive recipients of curative services and few patchy preventive services, to an active community taking responsibility for primary health care, who would intelligently demand and utilize the inputs of health services.

## **VI. FACTORS INFLUENCING SUCCESS OF COMMUNITY PARTICIPATION**

### **A. LEADERSHIP FACTORS**

Study of large number of projects besides the 19 studied in depth by ISHA, has shown that the critical factor in the successful projects, has been leadership which could be characterized as follows.

#### **1. Commitment to health and Community Development:**

In almost all these projects, strong commitment of one or two persons to health care and/or community development has been able to change the populations of large number of villages from subservient, poor, apathetic, dependent, fragmented groups, to transformed communities.



## 2. Cognitive Flexibility and Perceptual Ability:

Next to the commitment of the leadership, a critical factor has been the willingness and ability of the leader/health agency to go beyond health to meet developmental needs of the community, and a willingness to accept that health is just one of the felt needs and not a priority need. As a natural consequence, in these projects, the community's participation in the agencies programmes, including health programmes, has been greater.

3. Development of second line leadership in the community to take over responsibility. In such projects, the population covered by the project could be expanded extensively, and rapidly. Where the leadership of the project was committed more to a service programme, in terms of providing services and inputs, and to the achievement of preconceived health care targets, rather than to development of the people in the community to take up the responsibility of health care, the people's participation has been limited largely to availing services. This is evident in the hospital out-reach projects. It is also evident in projects/Government Programmes where the emphasis is on satisfying the demand/objectives imposed by the donor agencies or mandatorily trying to spend certain budgeted amount within a time-bound period.

## 4. Community-based Leadership rather than institutions-based Leadership

Wherever the services to the Project areas were given as outreach services, from an institutional base, with a preplanned package of services, in spite of training village health workers and widespread health education, community participation has been limited. In these projects, it could at best be termed as community acceptance and cooperation for the health and family welfare services. Conversely, the highly successful Projects are those where most of the Project activities are centered around the community and its needs, rather than the institutional goals and objectives. In the Projects where the Project leaders settled down in the service area and identified with the local people, even though the project might have started work with provision of some basic curative services, community involvement in health evolved over a period of time. It appears that people need to identify with the individuals and agency first, before a consensus emerges on the commonality of goals of the agency and the community, and brings forth participation.



### **5. Continuity of Leadership**

A notable feature of the successful voluntary sector projects, and in the Government sector, of the Municipal cooperation of Hyderabad and Visakpattnam is the maintenance of a stable middle management cadre of the Urban Community development Projects in these cities. This finding has enormous relevance in the health system of our country, wherein there is high turnover of doctors and other paramedical personnel in the rural areas, due to repeated/compulsory transfers, and we expect the Primary Health Centre to achieve community participation.

## **B. COLLABORATION WITH THE GOVERNMENT AND OTHER VOLUNTARY AGENCIES**

6. Next to the leadership factors affecting the success of a project, has been the strategy of collaboration with several government and other agencies

7. In all the outstanding successful projects, the funds for development (mostly obtained through collaboration with the governmental and banking agencies) were not given as charity or unconditional input. The philosophy of all these projects has been, that sustained human and socio-economic development cannot come out of charity, but through development of human resources to utilize inputs, create family and community assets and return the input (loan) to be recycled to beneficiaries in the community.

## **C. SOUND REFERRAL SERVICES**

8. Projects with sound referral services to back up the primary health care services, have been able to build up community faith in the agency, acceptance and participation in health care. For this, it is not necessary that the first level referral services should be highly sophisticated with specialists and super specialists. Provision of reliable medical, surgical and obstetric services to deal with the most common emergencies, with a bare minimum of physical facilities even in improvised rural buildings, was enough to gain the confidence of the people.

## **D. ABILITY TO RECOGNIZE AND UTILIZE THE STRENGTH OF THE LOCAL COMMUNITY**

An important feature of the successful projects has been the ability of the leadership of the external agency to capitalize and build on the strengths of the local community, and harness it to overcome



other hurdles, chiefly the hurdles of caste and class divisions, and extreme poverty. Every community irrespective of its socio-economic or geographic location has some strength (s). The motivated leader will find these and build upon them.

## **E. COMMUNITY BASED CADRE OF HEALTH WORKERS**

(10) All the highly successful projects (in terms of enlisting community participation) have one common characteristic. That is, development of a bonafide community-based cadre of health workers given proper training, on-going guidance, supervision, and motivation from the health center leaderships for successful utilisation of community health workers. It is highly essential to build up a sense of partnership between the PHC/hospital team and the community health workers.

## **F. INTEGRATION OF TRADITIONAL HEALTH SYSTEMS AND PRACTICES WITH MODERN SYSTEMS AND TECHNOLOGIES**

(11) In almost all the successful projects, the indigenous skills (whether midwifery or traditional medicines) which did not clash with modern preventive practices like aseptic delivery procedures, immunization and ORT, were added to traditional midwifery and child care skills, rather than compelling local dais and local practitioners to abandon effective age-old remedies and skills. The latter attitude to strategy would result in a community hostility towards change, rather than helping to bring about change in health practices.

## **VII. RECOMMENDATIONS**

1. The state and periphery level leaders in government at district, block and local levels be trained in the process of community participation and collaboration with other health-related sectors in government and with voluntary agencies.

2. Highly motivated and committed workers be selected and placed at various levels (from national to periphery) to make community participation a success.

3. The Officers should be placed in positions for atleast five years, given realistic targets and adequate resources should be provided, This management by objectives approach will help build involvement and commitment.

4. The voluntary agencies should be more actively involved in health programmes, in training as well as in initiating collaborative



projects With the government sector, particularly in the 90 districts with poor MCH status and high birth rate.

5. Innovative reward systems should be initiated to promote effective community health development programmes through community participation at local, Block, District, and state levels.

6. Publication on community participation, highlighting case studies, could be printed by the Government of India for wider circulation to all state, district and PHC level officers, for education and development of the community, professionals and administrators.

## REFERENCES

1. Government of India National Health Policy Document, 1983.
2. Government of India CSSM Review, Newsletter, January 1993.
3. Restricted Circulation Document SEA/RC 44/14 of WHO/SEARO
4. UNICEF- The state of the world's Children 1991.
5. Government of India, MOHFW: Review of UIP-country overview, September 1992.
6. Government of India, Document for Restricted Circulation September 12, 1991.
7. UNICEF: State of the world's Children, 1994 as quoted in the The Hindu December 28, 1993.
8. Sahni, Ashok Ed: Health of the youth and the Female Child, health, Geneva.
9. UNICEF 1990 Urbanisation and its implications for child health, Geneva.
10. Government of India, Central Bureau of Health Intelligence : Family Welfare Year book 1987.
11. Indian Society of Health Administrators : A study of Health Status of Youth in the Urban Slums of Bangalore, unpublished.
12. Sahni, Ashok and Xirasagar, Sudha. Community Participation in Health and Family Welfare, \_ Innovative Experiences in India, ISHA, Bangalore, 1990.
13. Sahni, Ashok : The Third Force in health Care-The Voluntary Sector ISHA, Bangalore, 1992.
14. Government of India, Central Technical Committee Department of woman and Child Development, ICDS- Evaluation and Research 1975-88, New Delhi 1989.



**TABLE-1**  
**Present Status of MCH in India vis-a-vis HFA, goals**

	current Level	HFA Goals For 2000(1)
1. Infant Mortality Rate (SRS 1990) (per thousand live births)		
Rural	86	
Urban	51	
Combined	80	Below 60
2. Crude Death Rate (SRS 90)	9.6	9.0
3. Perinatal Mortality (1)	67 (1970)	30-35
4. Pre- School Child Mortality -1-5 years (1)	24 (1976-77)	10
5. Maternal Mortality Rate(2)	4	Below 2
6. Babies with Birth Weight below 2500 gms(% of babies)	30% (3)	10%
7 Crude birth rate (SRS-90)	29.9	21
8. Effective Couple Protection % (GOI MOHFW)	44.1%	60
9. Pregnant mothers receiving Ante-natal Care	80% (5)	100%
10. Deliveries by Trained Birth attendants (1983-88)	33% (4)	-
11. Immunization Status (% coverage)		
a. TT for Pregnant Women (88-89)	69%	100%
b. DPT Infants (3rd dose)	-	85%
c. Polio 3rd dose	Approx	85%
d. BCG (infants)	80%	85%
e. DT (5 years)		85%
Total Under - Five Mortality Rate	146(4)	85%

1. Government of India : National Health Policy Document, 1983
2. Government of India CSSM Review, Newsletter, January 1993
3. Restricted Circulation Document SEA/RC 44/14 of WHO/SEARO
4. UNICEF\_ The State of the World's Children 1991.
5. UNICEF- The State of the world's Children 1992.



TABLE-2

Programme	Premises on which based/problems expected to be tackled	Current level of efficiency/ Remarks
1	2	3
<p>Universal Immunization Programme</p> <p>Universal Coverage of all infants with BCG DPT, Polio and Measles vaccine (atleast 85%)</p> <p>-Universal coverage of pregnant mothers with Tetanus Toxoid</p>	<p>a. Premises at the start of the Programme:</p> <p>i. Approx. 20-25% of infant deaths caused directly by vaccine-preventable diseases</p> <p>ii. Approx 15%-25% under five deaths due to acute Resp. Infection are caused by measles, whooping cough and diphtheria.</p> <p>Therefore, UIP targeted at the high IMR and U 5 mortality.</p>	<p>a. Child immunization in respect of measles reaches 80-85% coverage with range 57-90, (5)</p> <p>b. Coverage of Pregnant mothers approximately 60% range 53%-97% (5)</p> <p>c. As UIP is being integrated into primary health care and support as a vertical program being reduced, indications are that efficiency is decreasing</p>
<p>2. Integrated Child Development Scheme provides for a package of child Development services to children aged 1-5 years including</p> <p>a. supplementary proteins calories nutrition to urban poor and rural poor children aged 1-5 years, pregnant women and lactating mothers.</p> <p>b. Facilitating services to facilitate other health programmes for women and children</p>	<p>a. Malnutrition is the major killer in 1-5 age group, 10-15% of children are moderately to severely malnourished.</p> <p>b. Nutrition supplementation to pregnant/lactating mothers will reduce low birth weight incidence, improve IMR picture and under-fives health.</p>	<p>Currently about 70% of taluks are covered. Impact studies show significant improvement</p> <p>under five child health status in ICDS areas Pregnant Lactating mothers have not utilized the service much; therefore its influence on low birth weight and perinatal mortality would be negligible.</p>



1

Vitamin A prophylaxis to children aged 1-4 years against nutritional blindness

2

a. Approx. 55,000 children become blind every year due to vit. A deficiency  
b. Vitamin A deficiency is a predisposing factor for acute resp. Infections and diarrhoea diseases both major Killers among infants and under-fives  
Thus the Programme Targets to lower under five mortality

3

Several evaluations have shown coverage of about 10-40% (13)

4. Iron and Folic Acid Tablets for pregnant mothers and children aged 2-6 years

a. Anemia in mothers directly causes 20% of maternal mortality and indirectly is the cause of mortality due to bleeding, and toxemia

Several studies have shown varying coverages of average 50% (2)

b. maternal anemia leads to low birthweight, and anemia in infants which predisposes to death in infancy. reduce maternal infant, under five mortality

5. School Mid-way Meal Programme

a. Under-nutrition in school going children affects educational performance and continuation of education. Nutrition supplementation will help reduce dropout.

Programme not evaluated on large scale so far.

b. Mid-day meal will be an incentive for continuation of primary school education ; prevents dropout.  
This programme aims to support the achievement of the goal of universal Primary education.



**6. Diarrhoeal disease control programme.**

- a. Popularization of ORS for diarrhoea
- b. Long term strategy to ensure universal availability of safe drinking water

a. In 1983 when the National Health Policy was adopted about 25% of infant mortality and 1-4 years mortality was due to diarrhoea

b. Oral Rehydration can prevent 90% of diarrhoeal morbidity and mortality-This programme targets to lower infant mortality and under-five mortality

a. Although large scale evaluation studies not done so far. Some degree of success has been achieved in popularization of Oral rehydration as reported in several small scale studies.

b. During water and sanitation Decade of 1980-90 most of rural and urban population has been provided access to safe water. Some hill tribal areas still face a critical situation especially of Bihar, Orissa, MP, UP and Andhra Pradesh.



# APPENDIX-I

## SELECTED INDICATORS FOR 90 DISTRICTS

### WITH CRUDE BIRTH RATE - 39

STATE	DISTRICT	SEX RATIO (PER 1000 MALES)	PERCENTAGE OF LITERATES (FEMALE)	MEAN AGE AT MARRIAGE	NON-AGRI LABOUR AS % OF MAIN WORKERS	CBR	IMR
1	2	3	4	5	6	7	8
BIHAR	1. Nawada	1,002	12.77	14.7	4.9	39.85	95
	2. Saharsa	930	9.16	15.7	2.8	40.61	113
	3. Samastipur	972	12.77	15.9	12.4	39.09	107
	4. Katihar	928	11.34	16.2	6.8	39.61	115
	5. Gaya	962	15.25	15.4	6.3	39.82	101
GUJARAT	6. Kachchh	999	26.68	18.2	22.7	39.38	89
	7. Banaskanta	945	11.36	18.5	17.3	40.80	94
HARYANA	8. Bhiwani	898	16.30	16.1	10.3	39.40	86
KERALA	9. Malapuram	1052	56.34	17.8	32.3	29.32	40
MADHYA	10. Sehore	907	9.78	14.8	8.9	40.77	146
PRADESH	11. Rewa	969	11.35	14.4	8.1	40.55	173



1	2	3	4	5	6	7	8
MADHYA	12. Guna	882	9.26	15.0	16.3	42.03	150
PRADESH	13. Damoh	925	16.52	14.8	43.4	42.94	150
	14. Gwalior	845	25.98	15.8	46.8	40.71	118
	15. Panna	913	8.66	15.0	14.3	45.54	185
	16. Raisen	908	11.51	14.9	15.8	42.62	135
	17. Hoshangabad	908	21.88	15.5	18.1	40.89	163
	18. Vidisha	881	13.07	14.9	23.6	43.35	144
	19. Tikamgarh	883	8.44	14.3	9.2	44.48	195
	20. Bhind	827	14.67	14.7	25.3	40.17	129
	21. WestNimar	954	12.19	16.4	6.5	39.73	137
	22. Sagar	891	21.11	14.8	57.5	43.23	164
	23. Jhabua	985	6.5	17.9	4.5	42.65	116
	24. Bhopal	874	37.38	16.9	58.2	39.61	82
	25. Shivpuri	855	8.12	14.8	9.7	41.58	150
	26. Betul	973	17.42	16.9	7.2	40.69	158
	27. Chhatarpur	864	10.24	14.5	15.4	42.19	182
	28. Morena	834	10.09	14.8	15.2	44.57	132
	29. East Nimar	939	18.91	16.1	10.0	39.65	131
	30. Datia	853	12.26	14.8	20.3	39.97	156
	31. Dhar	966	10.27	16.3	4.4	39.39	116
	32. Satna	936	13.26	14.8	17.4	41.20	181



ORISSA	33. Baleshwar	977	28.26	16.2	24.0	41.69	132
RAJASTHAN	34. Jodhpur	909	14.47	16.4	15.7	41.55	86
	35. Udaipur	977	10.76	15.8	22.4	40.65	120
	36. Sawai						
	Madhopur	867	8.16	15.1	14.4	43.34	141
	37. Kota	888	17.39	15.2	36.8	40.14	112
	38. Jhalawar	926	9.27	14.7	8.6	40.16	124
	39. Jalor	942	4.43	17.3	10.6	41.59	104
	40. Dungarpur	1,045	7.97	16.5	21.6	45.12	111
	41. Bharathpur	831	10.08	16.0	30.9	44.02	147
	42. Banswara	984	7.50	16.9	18.0	42.39	108
	43. Ajmer	922	21.92	15.4	23.4	39.08	125
	44. Sirohi	963	9.92	17.1	29.6	39.75	121
	45. Ganga nagar	874	14.16	16.8	26.2	39.15	82
	46. Jaipur	894	17.18	15.2	24.5	41.62	108
	47. Sikar	963	9.08	15.0	17.2	41.00	95
	48. Bikaner	891	17.57	15.4	35.4	41.32	62
	49. Pali	946	8.83	16.2	12.7	40.14	130
	50. Barner	904	3.71	16.5	14.1	41.45	102



1	2	3	4	5	6	7	8
	51. Alwar	892	11.38	16.0	19.2	41.36	128
	52. Bundi	887	8.92	14.4	21.6	40.68	125
	53. Nagaur	958	7.12	15.3	6.8	41.46	96
	54. Jhunjhunum	956	11.40	15.5	12.9	39.98	92
	55. Tonk	928	8.28	14.0	19.1	43.65	148
	56. Churu	954	9.81	15.3	7.4	42.08	81
<hr/>							
UTTAR							
PRADESH							
	57. Farrukhabad	821	19.08	16.3	81.4	39.49	122
	58. Pratapgarh	1,001	18.81	14.8	7.4	40.15	126
	59. Manipuri	821	18.49	16.1	58.5	39.52	121
	60. Banda	860	8.61	15.8	7.1	39.85	98
	61. Azamgarh	1,020	12.20	15.2	19.2	40.20	110
	62. Shahajahanpur	812	10.79	16.4	59.2	40.44	167
	63. Tehri Garhwal	1,081	9.42	16.8	1.3	41.18	99
	64. Hardoi	821	9.52	16.5	38.7	42.16	173
	65. Moradabad	842	10.93	17.4	74.1	42.47	126
	66. Aligarh	840	16.24	16.7	57.1	40.56	129
	67. Lalitpur	851	9.96	14.5	26.8	42.31	138
	68. Pilibhit	841	9.32	16.7	54.1	39.89	147
	69. Deoria	981	9.07	16.1	7.8	39.97	120
	70. Bulandshar	863	13.34	16.8	49.1	40.59	127
	71. Gorakhpur	940	10.36	15.2	9.1	40.41	123
	72. Buduan	801	7.54	16.5	56.7	41.06	155
	73. Saharanpur	832	18.06	17.6	59.9	39.24	96



1	2	3	4	5	6	7	8
	74. Sitapur	841	8.38	16.4	33.2	39.43	143
	75. Basti	921	7.94	15.0	9.5	41.29	164
	76. Sultanpur	970	9.37	14.9	9.3	40.87	151
	77. Etah	821	13.10	16.4	60.6	39.67	170
	78. Jaunpur	1,001	10.89	15.2	12.5	41.83	118
	79. Agra	821	19.92	16.6	75.6	41.07	115
	80. Bareilly	830	12.33	16.8	79.2	39.80	146
	81. Gonda	890	5.45	15.4	7.3	39.69	157
	82. Allahabad	890	12.81	16.5	16.3	39.69	110
	83. Nainital	841	27.10	17.0	17.2	39.43	93
	84. Meerut	831	20.30	17.1	64.3	39.76	102
	85. Bijnor	863	14.76	17.9	76.7	42.93	120
	86. Raebareli	940	10.47	15.7	8.7	40.92	172
	87. Ghaziabad	821	21.32	16.9	69.5	40.50	114
	88. Rampur	843	8.88	17.4	70.9	43.62	150
WEST	89. Maldah	949	14.22	15.9	43.8	41.29	128
BENGAL	90. Murshirabad	959	17.75	15.9	81.8	39.84	104



# INVOLVEMENT OF WOMEN IN ACHIEVING FERTILITY DECLINE THROUGH INCOME GENERATION ACTIVITIES: AN EXPERIENCE FROM THE WOMEN'S PROGRAMS OF THE BANGLADESH HEALTH AND FAMILY PLANNING SECTOR.

*Faroque Ahmed M.A.M.H.S.*

## 1. INTRODUCTION

For about more than a decade, quite a number of initiatives were undertaken in Bangladesh by both government and non-government agencies to involve women particularly from the less advantaged groups in the development process of the country. In the NGO field the work of BRAC and Grameen Bank and in Government sector the works of the Bangladesh Rural Development Board (BRDB) and the Directorate of women's Affairs are worth mentioning here and the results of these initiatives are quite encouraging for us as well as for other developing countries. Grameen Bank has started mobilizing resources to test the model in other developing countries of the world and both USAID and the World Bank have made some grant fund commitment for this work.

Some other success stories in Bangladesh health sector are in EPI and ORS programs where the involvement of people made a significant impact of these programs to the health benefits of women and children. I shall be limiting my presentation to public sector initiatives taken under the umbrella of population programs.

## 2. BACKGROUND OF THE POPULATION AND HEALTH SITUATION

The Population and Health situation in Bangladesh is characterized by the (i) enormity of the population pressure, (ii) extra-ordinary level of poverty and illiteracy that hurts the country's productivity as well as its health status, (iii) generally gloomy picture of morbidity and mortality, and (iv) remarkable differential between the health status of females and that of males.

## 3. STATUS OF WOMEN

The overwhelming majority of women in Bangladesh are not only poor but also caught between two vastly different worlds-one deter-

---

*Mr. Faroque Ahmed, Program Officer, Population and Health Office of the  
World Bank Resident Mission in Bangladesh*



mined by culture and tradition that confines their activities inside family homesteads and the other shaped by increasing landlessness and poverty that forces them outside into wage employment for economic survival. Over the past two decades, norms segregating and protecting women have been breaking down. However, women's access remains limited to services that can equip them to acquire knowledge, obtain essential social services, and overcome gender-specific constraints to labor force participation. If Prepared for the outside world, women are vulnerable, have limited economic opportunities, and continue to occupy subordinate positions in the household and the economy.

The social, cultural and religious traditions shape the women's reproductive role. A daughter is married off as soon as she reaches puberty and immediately joins the high fertility pattern.

#### **4. THREE WOMEN'S PROGRAMS**

Recognizing that an enhanced status of women is critical to economic development of the country and long - term reductions in fertility, Government of Bangladesh started three programs to assist women through Women's Cooperatives, Mother's Centres and Women's Vocational Training, in 1976, under its multisectoral population program to reduce country's population growth.

From a modest beginning, the three programs have expanded to cover 210+100 (new from late 1993) = 310 thanas (sub-districts), of which some are overlapping. The cooperatives cover 100+(100 from late 1993) = 200 thanas, mother centers 80 thanas and vocational training 30 thanas. They provide gainful employment to women through income generation and impart nonformal education with emphasis on family planning, health, nutrition and child care. Program inputs like training and credit facilities have helped women earn some income which they otherwise would not have earned. They have also helped women reduce fertility as the contraceptive prevalence rate (CPR) is higher in program areas than in non-program area.

The three programs have reached many women over the past 15 years. Coverage has been in the range of 730,000 women (Mother Club-540,000, Cooperatives-140,000 and Vocation Training-50,000). These numbers may not seem striking in the context of the size of the country's women population, but most members are innovators who serve as examples to others, both in self employment and contraception; they are scattered widely in rural areas; are now better informed; and facilitate a two step flow of information and innovation.



Evaluation of the three women's programs by different agencies since 1979 have indicated that the programs provided some gainful employment to women; that project women's knowledge and practice on contraception have increased, that members of these three programs have made some success in persuading other women of the community to adopt family planning; and that members have undertaken agriculture-related income-generating activities more widely. The contraceptive practice rate among the members of the three programs ranged from 54% to 60%. Total marital fertility rate (TMFR) for the beneficiaries of three women's programs were much lower than the national TMFR. The level of knowledge of the program women on MCH was much higher than that of the non-program women. The monthly income of the members of the three programs varied from Tk. 200 to Tk. 262.

However, the three programs also suffer from some common deficiencies. Such deficiencies include (1) inadequate skill development in training; (2) inadequate credit; (3) inadequate marketing facilities; (4) poor quality of products; (5) limited scope for trades; (6) limited scope for utilization of training; (7) lack of common strategy for graduating the members who are older in age or have long involvement; and (8) difficulties faced by members to have access to contraceptive services. Some of these deficiencies have been addressed lately, though not adequately.

## **5. RURAL WOMEN'S COOPERATIVE PROGRAM (RWC) OF BRDB**

Now I shall try to address very briefly one of the three women's programs-namely the Women's Cooperative program implemented by the Bangladesh Rural Development Board (BRDB).

### **A. BACKGROUND AND DEVELOPMENT**

Rural women's cooperative program started in 1976 as a pilot project with financial assistance from the World Bank consortium support to the population sector. During the first phase (1975-80) 19 thanas were covered and 728 cooperative societies were formed with a membership of 31,527. The RWC is linked to the Thana Central Cooperative Association (TCCA). In the second phase (1980-85), the program expanded to 40 thanas and a total of 1975 cooperative societies were formed by June 1985 with a total membership of 69,839. the share capital and savings deposited amounted to Tk. 10.3 million and Tk.30.0 million had been disbursed to 31,337 members (53% of the



total number) as short term loan from a public sector commercial bank. The size of the loans were Tk. 500-Tk,1000. In the third phase (1985-90) the program was expanded in 100 thanas and an amount of Tk. 132 million was expended during this phase. About 46% of the fund was spent for the training, fellowship, study tour, etc. The cost per RWC member amounted to Tk, 946 only and cost per thana Tk. 1.3 million. Since its commencement, the program passed through 3 distinct phases and currently is in the fourth phase.

The fourth phase begun in 1990 for a period of 5 years in 100 thanas , with external assistance from the World Bank. Plans were made to phase out 40 thanas which were taken in first and second phases and take 40 new thanas in this phase. As the Government is pursuing the policy of involving women in the additional 100 thanas from its own resources.

## **B. OBJECTIVE**

The basic objective of involving women in this socio-economic development and thereby to attain small family norm remained the same in all four phases of RWC program: The specific objectives during the current phase are:

- to organize rural poor women into cooperatives and indicate necessary opportunities for their participation in the development work.
- to motivate the target group for planned parenthood.
- to provide traditional and non-traditional skills training to the target group to enhance efficiency for income generation.
- To ensure supply and services for economic activities, family planning, MCH and immunization services, etc.

## **C. STRATEGIES**

- Raising the role of women, with lowest social and economic segments of society, in productive activities through cooperative institutions;
- Improvement of credit facilities for the members of the cooperative through loan program;
- Creating opportunities for their participation in the development activities through specialized training;
- Exposing more women to family planning, MCH and primary health care; and



- Establishing effective links with the FP Directorate and other women's projects for coordination of the project activities.

#### **D. CRITICAL REVIEW OF THE RWC**

The following salient features emerged from the recently conducted in depth review of the program:

i) Generally, cooperatives were formed and managed by the affluent/influential women in the community. The general members are least involved in decision making and they got the residual benefits from the program.

ii) Weekly training on awareness raising at TTDC (Thana Training and Development Centre) for the managing committee members of RWCs were held regularly and they were responsible to transfer their knowledge to the other fellow members in a weekly gathering at the village cooperatives which did not work well.

iii) In the current phase, the scope for vocational training has been broadened by introducing new trade and increasing its institutional capacity for training. But little follow up is done to see how women are using such training and what problems they are facing.

iv) The members of RWC, accumulated substantial capital (Tk.35million) through small savings and purchase of shares. Credit ceiling from the commercial bank has been increased from Tk.1000-5000. The members of the executive committee had greater access to credits than general members. Credit recovery rates were above 90% in first two phases and declined to 70% in the third phase due to some confusion about a Government decision to exempt agricultural loans up to a certain amount.

v) The most common income generation activities undertaken by RWC members with the loan money were cattle and poultry rearing, paddy processing, plant nursery, vegetable gardening and sewing, which were traditionally done by men and women had supportive role. But this tradition got changed and women are taking the man's role where such activities are undertaken with their loan money. In the current phase some non-traditional trades i.e. pisciculture, leather processing and preparation of water seal latrine have started. By the year 1990, the average monthly income accruing from loan received by an RWC member was estimated at Tk. 252.

vi) By the end of the third phase of the program (1990), the contraceptive use rate among the cooperative members was as high



as 56%, while among the non-members in the program areas it was 41% and non-program areas it was 40%. Total marital fertility rate was much lower among the cooperative members (3.8) than that among the non-members in the program area (4.7). The members of the cooperatives were found to possess knowledge on nutritional matters such as causes and treatment of night blindness and vitamin A enrich vegetables and fruits. The members of the RWCs also had better knowledge than the non-members on maternal and child health care.

It was observed in the study that to make the programs more effective, followings are needed: (i) formation of RWCs, in a democratic manner, (ii) helping the village cooperative societies to grow independently and manage their own affairs rather than being under the control of the thana administration, and (iii) making provision for cooperators to earn regular and sufficient income with least dependence on men.

## 6. SUSTAINABILITY

A study on cooperatives in Bangladesh pointed out that cooperative rules and laws inhibit, rather than support, self-management and greater financial self-reliance. It also made following suggestions for ensuring sustainability.

(a) changing the attitude of the government in terms of supporting rather than controlling development of cooperatives, i.e. the governments should provide the frame work for cooperatives to develop on their own.

(b) reorganization of governments role from direct intervention to facilitation and from a focus on quantity to that on quality.

Some NGO's such as, BRAC, Grameen Bank, and Nigera Kori have attained some success in respect of self financing of their income generation and family planning programs. The NGOs have identified the following factors as sustainability indicators: (a) Savings development, (b) Capital formation, (c) Training on development of different skills like managerial, financial know-how, and (d) Prevention of oppression.

A careful review of the NGO experience and the limited experience of BRDB where they have gradually transferred the financing responsibility to the local committees would be very useful to develop a common strategy to be followed for the long term sustainability of the programs.



## **7. GENERAL SOCIAL CHANGES**

Credit availability has increased for the rural population in general in the form of agricultural loans. More specifically, there has been a phenomenal increase in the amount of credit available to poor and landless families for non-farm operations. An undeniable change has taken place in terms of women's access to credit. The Grameen bank alone has over 800,000 female borrowers. As a matter of policy, most NGOs give preference to female borrowers. To exploit these opportunities women have to negotiate with NGO and Bank workers, develop skills in financial management and thus engage in integration with the world outside the 'bari' in a manner that would have been inconceivable 20 years ago.

## **8. CONCLUSION**

Expanded family planning services linked with improved curative health services, increased female education, and enhanced income earning opportunities for women will be required as major supportive measures for better female health and nutrition. Women's participation in the design and delivery of health services also must increase significantly for improvement in their health, nutritional, and fertility status to be sustainable.

## **REFERENCES**

1. Bangladesh Rural Development Board (BRDB) (1990): Project Proforma for Strengthening Population Planning Through Rural Women's Cooperatives.
2. Bangladesh Social Services Department (1990): Project Proforma for Use of Rural Mother's Centres for Population Activities.
3. Bangladesh Women's Affairs Department (1990): Project Proforma for the Women's Vocational Training for Population activities.
4. Planning Commission, et al. Study on Cooperatives in Bangladesh. Report. March 1989.
5. PIACT, Bangladesh (1993): Draft Final Report on In-depth review of the Three Women's Programs.



6. World Bank (1990): A World bank Country Study on the Bangladesh Strategies for Enhancing the Role of Women in Economic Development.
7. World Bank (1991): Staff Appraisal Report: Bangladesh Fourth Population and Health Project.
8. World Bank (1991): Operations Evaluation Department Report on The World Bank and Bangladesh's Population Program.
9. World Bank (1992): Bangladesh: The determinants of reproductive Change: Population and Health Sector Study.



# ROLE OF VOLUNTARY AGENCIES IN PROMOTING PEOPLE'S INVOLVEMENT IN HEALTH AND DEVELOPMENT OF WOMEN

*Tmt. Nandini Rajendran*

Health is a state of complete physical, mental, social, well being and not merely the absence of disease or infirmity. It encompasses all aspects of life fit together in a way that is comfortable, so that we can enjoy a vibrant life in work and play.

The goals of both professional and voluntary social workers are the same, that is, solving the problems of the community. While the professional social worker is restricted by the field she works in and to which she is attached, the voluntary worker has no such limitations. The field is vast and she comes to the aid of anyone who seeks her help. Every new problem may lead the voluntary to explore the hitherto unexplored realms.

Social Welfare is of special significance in a country like ours where nearly half of the population lives below the poverty line and does not get even two square meals a day. India has a long tradition of voluntary social work. Throughout the ages devoted social reformers and workers endowed with the spirit of selfless service to humanity have worked to combat social evils and fight for social justice. We have inherited a great civilisation rich in humane and spiritual values. Great saints and spiritual leaders kept the candle of our civilisation burning in the face of storms and hurricanes. The socio spiritual organisations have always played a prominent role in preserving and promoting ethical and spiritual values in society. The general welfare of the people depends upon human and spiritual values.

Prior to the evolution to the welfare state, Institutionalised social services like, schools, dispensaries and homes for the destitute were mostly run by charitable trusts and other social welfare organisations. But with rapid changes in the socio-political process and the evolution of the welfare state, the State has predominantly taken over the responsibility for meeting the social needs of its population. The role of voluntary welfare organisations, however, cannot be underestimated

---

*Tmt. Nandini Rajendran,*  
*Chairperson, Tamilnadu Social Welfare Board,*  
*485, Anna Salai, Nandanam, Madras-600035*



even in the newly emerging sociopolitical system. Public cooperation is always essential for the success of social development strategies and programmes. This assumes a special significance in the present day situation when we are faced with problem of rapid population growth.

## **FAMILY WELFARE**

Promotion of family welfare on a voluntary basis and extending full cooperation in the augmentation of primary health care facilities particularly, control and prevention of physical disability and blindness, welfare of women and children through the extension of nutrition programmes of pregnant women, nursing mothers and children are very much essential for the present society.

Health forms the base of all welfare and development. Healthy individuals are an asset to a nation. The health of a nation depends on the health of the individuals. For, it is only healthy citizens who are in a position to make optimum contribution to their own as well as the advancement of the nation. In order to harvest the full fruits of our developmental efforts and bring the desired improvement in the quality of life of the people, we must control our fast growing population.

In the words of our Late Prime Minister, Smt Indira Gandhi 'Family planning is a key to every individuals' and every family's betterment.'

India was the first country to adopt an official family planning programme. It forms an important part of our development strategy, scientific progress has made the process of limiting one's family cheaper, more effective and easier than ever before. What is now needed is mass adoption of these devices.

The advantages of a small family are too well known to need recounting. The desire of parents to have a male child often leads to large families. Thus the family planning programme is linked to the removal of prejudices against women in our society. Also, the programme will succeed as women become better educated and more aware of their own rights and obligations. We need the Family welfare programme not because we are against children but because we want every child to have the best opportunity possible in life. We want our children to inherit a better world than our own. This is the aim of every father and mother and this is the ultimate objective of planned development.

The need for the creation of a district level agency to provide basic medical and health services in every village is to be emphasised.



## NUTRITION AND HEALTH

Children who develop severe malnutrition die, unless proper treatment is available in time which is seldom. Many others, not recognised as malnourished, easily die of measles, diarrhoea, respiratory infections and other common diseases of childhood which are not serious in well nourished children. Others who survive are often retarded in their growth and development physical and mental, and become the small chronically malnourished and uneducated parents of future generation with the same fate.

Under any circumstances, breastfeeding is the ideal type of feeding for children during their first months of life.

## INFANT MORTALITY

A major offshoot of the health scene was the high incidence of infant mortality in India, the highest in the world; even here the infant mortality in Uttar Pradesh is higher than the national average while Kerala's is the lowest mainly due to the progress achieved by the state in Women's Education.

Infant mortality rate is the 'most sensitive index of health and living of people'. In India, IMR is still very high, though over the years, there has been a steady decline in infant deaths.

Premature births account for nearly one third of all infant deaths. Respiratory infections, diarrhoea in new born, and malnutrition account for another one third of deaths. Together, these causes account for nearly 67 percent of all infant deaths.

Most of these causes can be prevented with judicious application of existing health resources. Low birth weight can be improved by increasing the nutritional status of the pregnant women. In our country every year 7-10 million babies are born with low birth weight, accounting for nearly one third of all the total births.

It has been observed that in some parts of Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan where IMR is far above the national average, a major contributing factor is neonatal tetanus. A sample survey (1981) revealed that the proportion was highest for U.P. (81.7 percent rural and 59.3 percent urban). It is significant that no death due to tetanus were reported from Urban Tamil Nadu and Pondicherry. In some states like Bihar, Maharashtra, more tetanus deaths occurred in urban area compared to rural areas. A majority of mothers did not receive antitetanus immunisation and a vast majority of deliveries were conducted in unhygienic conditions by unqualified dais or family



members. Neonatal tetanus is still a leading cause of infant mortality in rural areas, prematurity is the major villain of the piece in the urban areas. Pneumonia, respiratory disorders, and infection like malaria and typhoid are more common in rural areas.

## **CHILD MORTALITY**

Diarrhoea is a major killer of children. Incidence of acute diarrhoeal diseases is about 500 per 100 infants. About 15 lakhs children under 5 years die each year of diarrhoea. Majority of these deaths can be prevented by proper health education and widespread use of oral rehydration solution.

## **WORKERS IN BEEDI INDUSTRY**

All workers in beedi industry should be brought under better medical care. Instead of keeping an outpatient department in hospital, mobile medical units could be arranged to render medical aid at door steps.

Considering the large number of children these women produce, family planning must be undertaken intensively giving incentive measures.

ill effects of tobacco should be well explained.

The women should be provided with information regarding alternative ways of earning without being exposed to tobacco, such as tailoring, weaving, basket making etc.

Social Education regarding the age of marriage, the minimum age at which delivery could be safely conducted, early marriage, both physically and mentally, should be highlighted and explained using mass media and other communication strategies.

Voluntary organisations and Government can render help and support to improve their financial and social status which in turn will enhance their status.

For children of tobacco workers formal schooling may not be possible. Alternative system of education may be provided on a nonformal basis to improve their educational status, Voluntary organisations can organise such programmes.

They live in insanitary conditions, exposed to a variety of diseases like AIDS, STD, hepatitis, tuberculosis etc. Let's not forget that they are our own people who are entitled to minimum medical care and health education.



## **TRIBAL AREAS**

Since the Primary Health Centre is far away from the tribal settlements, emergency cases like maternity, accidents, snake bites etc. do not receive timely treatment. Hence, there is an urgent need to set up primary health sub-centres close to the settlements of tribals.

A study reveals that almost all the women folk were afraid of tubectomy, because they thought it was dangerous and fatal to their health. If we take up the living conditions of tribal community, it is very much discouraging. Basic necessity is to make available pure drinking water to the tribals.

To remove unfounded fears about family welfare the development officials and voluntary agencies should explain to them the merits and benefits of such programmes. In other words, appropriate population/health education should be given to them.

## **ROLE OF VOLUNTARY ORGANISATION**

Awareness creation is the toughest job especially because of the high rate of illiteracy and the traditional value system. Therefore, the change agent will require a lot of patience and skills in order to stimulate the people to understand the importance of nutrition. They are the best agencies to persuade the people to accept the right kind of things for achievements of the desired goals.

Education is of primary importance in getting the people acquire knowledge regarding health problems, the need to prevent the same through simple processes of immunisation and accept the fact that prompt and proper treatment of disease is not only good for the individual concerned but also for the community as a whole. The voluntary sector can in direct collaboration with the Ministry of Education, Health, Social Welfare etc. take this message to the doors of the individuals/families and as such to the community as a whole. Health care should be such as to involve the community ensure their participation so that it is maintained in a spirit of self-determination. Here, it is acceptance which is stressed for anything enforced is not continued and loses its meaning. Therefore, the contact of individuals, family and community with the National Health Programmes can best be served by bringing health care as close as possible to where people work and live. The voluntary sector can reach the people where they work and live and can therefore help in the propagation of the various health programmes of the Government.



But there are built-in deficiencies which make the task of the voluntary sector difficult to implement. While there are certain social services like education, nutrition, sanitation etc. which can be undertaken by voluntary organisations, health is a specialised subject and can only be effectively carried out through the help of medical and para medical staff. With all the best intentions group of voluntary workers, dedicated to their jobs, cannot administer medicine or give an injection or even diagnose a disease.

For this purpose one requires a doctor or atleast a paremedical health worker. Any Voluntary organisation taking on this role must necessarily work in close cooperation, with the ministry or have medical and or para-medical persons as its members.

While the voluntary sector can create an atmosphere which is receptive of family planning, immunisations and other health problems, the actual work has necessarily to be done by the qualified persons. It is here that Government can help the voluntary sector to carry out the programmes set forth by the ministries concerned. The most crying need in this field is para medical staff and/or trained health workers. Those voluntary sector organisations who are willing to undertake health care schemes should be asked to nominate members who would be given the necessary para-medical training. Then they can go down to the community, the family and the individual to see that the primary health care schemes are implemented in full.

Any health programme to succeed must necessarily have the support of the Government agencies, for this being a specialised field ordinary voluntary organisations cannot work on their own without having the necessary qualified persons as its members. To take the primary health care scheme to the very basic roots, I would like to make some suggestions:

1. Literacy is of major importance for health. It enables people to understand health problems, the ways to solve them and above all it involves them in their programmes. Here the voluntary sector can be of immense help.

2. Concentrated publicity through the media of radio, television and above all the cinema. Short documentary films on health care dealing with various diseases should be shown in every cinema house. At the village level, the same can be shown through the mobile units.



3. Train large number of health workers and paramedical staff who can not only man the dispensaries but go out to the community, mohallas, the families and the individual.

4. Have multipurpose camps. Not only a family planning or an eye camp but a camp where a number of health problems are discussed and slides or better still films shown on various diseases, their causes and their cure.

5. Make the clinics or dispensaries easily available to those who need them most. This again mean taking them to the people rather than the people having to trudge to them.

6. Ensure that necessary medicines and drugs are available. Many a scheme has failed for want of the required medicines and drugs.

7. Involve the voluntary sector in all these activities.

Millions of people are trapped in the vicious circle of poverty, malnutrition, disease and despair that saps their energy, reduces their work capacity and makes them a burden on society. If the voluntary sector is given the necessary aid there is no doubt that working in full cooperation with the Government and its agencies primary health care can be taken to the people who need it most. It is my opinion that the voluntary welfare agencies can coordinate in the following ways:-

1. To conduct surveys and identify the health problems in a particular locality.
2. To provide information to the people about the location and availability of medical facilities such as Leprosy rehabilitation centre, cancer Institute, T.B. Sanatorium, child Health Care programme etc.
3. To conduct simple studies with the help of medical experts about the cause and effect of the vitamins and the finding may be exposed to the public.
4. To educate and enlighten the people on the prevention of disabilities through immunisation and nutrition.
5. To caution the people about the dreaded diseases like polio, measless, tetanus and tuberculosis.



6. To associate with related sectors like agriculture, animal husbandry, food, industry, education, housing, public works and other sectors in order to solve the nutrition problems.
7. To educate the villagers to make use of locally available leafy vegetables and fruits in plenty along with their regular food.
8. To conduct health education classes for primary school children in collaboration with Government Departments.
9. To educate the people, on cholera, tuberculosis, typhoid, skin diseases etc.



# WOMEN AND ENVIRONMENT HEALTH PROGRAMMES - EXPERIENCE AND RECOMMENDATIONS

*Anuradha Gadkari*

## I. INTRODUCTION

Environment plays a significant role in determining the well-being of a society because the real measure of health is not the utopian absence of a disease but the ability to function effectively within a given environment. It is well understood that development is the key to progress and every development project inflicts some changes in the environment, and since the environment keeps changing, good health is a process of continuous adoption to the myriad microbes, irritants and problems which challenge the man daily in the modern world of development and progress leading to increasing population, urbanisation and industrialisation.

Man is a social animal, he cannot live alone all by himself. He has to live maintaining harmonious adjustment with the environment. Health ultimately depends on society's capacity to manage the interaction between human activities and the physical and biological environment in ways that safeguard and promote health but do not threaten the natural systems on which physical and biological environment depend. This necessitates determining the carrying capacity of the environment such that stable and desirable climatic conditions, continuous availability of environmental resources viz., productive fertile soil, fresh uncontaminated water, and socio-economic conditions devoid of undesirable tension are maintained. It also includes smooth functioning of natural systems in spite of receiving wastes produced by human societies' domestic industrial and agricultural activities and contributing towards the maintenance of the ecosystem and human life.

The physical environment has a major influence on human health not only through temperature precipitation, or composition of air and water but also its interaction with the type of distribution of flora and fauna, "Biodiversity". The biological environment is a major influence



on the food supply as well as the reservoir and transmission mechanism of many diseases. As such Environmental factors that impair health include :

- Pathogenic agents, their reservoirs and vectors viz. *E. histolytica*, *S. typhosa*
- Physical and chemical agents present in the environment that are independent of human activities viz. iron or flouride contents in the water bodies
- Noxious physical and chemical agents added to the environment by human activities viz. pesticides, heavy metals.

As such keeping environment safe and healthy is a stupendous task and needs understanding of the various problems connected with it. In fact, Environment, wild life, Biodiversity, children are voiceless segments of the ecosystem and need concerned people to champion their cause. Women by virtue of their lower status in the society, *(despite being biologically stronger, 3 lakh more girls than boys die every year. In fact every sixth baby girl dies because she is killed at birth or allowed to die. And thankfully there are still people who ignore this statistics)*, also need to be given a priority when planning for a world future with safe and healthy environment, economic and social justice and equitable reallocation of resources for sustainable development.

On this background this presentation refers to environmental health, women, environment and their role, an environmental health programme for women, impediments therein and recommendations.

## II. ENVIRONMENTAL HEALTH

Environment encompasses a very large arena with multidisciplinary integrated factors. This refers to various aspects, the prominent being, physical, biological, geographical, chemical, social, economical, and cultural. The impact of all these aspects manifests into the human life pattern as well the quality of life, and health is a very important factor determining the same. As such it becomes imperative to understand the relation between environment and health, correct concepts of health and last but not the least, relation between environment and health as:

1. Biological environment of each individual will be different from the other. Some will be strong with good resistance, others may be weak and vulnerable to diseases.

2. Physical environment, in which a child grows or an adult lives influences health. Sanitary surroundings, clean environment free from contamination and diseases promote health, growth and development.



3. A Harmonious and congenial social environment with satisfactory interpersonal interactions will promote mental, emotional and social health.

4. Heredity influences growth and development. It determines physical structure based on genetic disorders.

5. The individual functions as a whole. Each dimension of health influences other dimensions. Physical illness may affect emotional well-being and social relationships. Social and emotional conflicts and pressures may develop into physical ailments.

## CONCEPTS OF HEALTH

- Health is related to all aspects of human life.
- Good health is imperative to attain life's goals.
- Health is much more than just not having a disease.
- Health means having a fit body, sound mind, capable of making life socially useful, productive and enjoyable.
- Proper health attitudes and practices based on correct information need to be developed right from childhood.
- Health is a state of complete physical, mental and social well-being but not merely absence of diseases.
- Health is a combination of physical, mental and social well-being. All these are dynamically inter-related.
- Sanitary surroundings, clean environment free from contamination and disease promotes health, growth and development.

Hence, health is not only treating and curing sickness or preventing disease but promoting well-being and keeping the environment safe.

## WHAT IS HEALTH ?

Health may mean different things to different people,

- To one it may mean feeling well, energetic and fit.
- To other it may mean being able to work, attend office and perform daily chores of life.
- It may mean being without pain and suffering.
- It may mean alleviation of diseases and cure.
- It may mean prevention of disease.
- It may mean promotion of maximum physical, mental, and social efficiency and productivity for individual and that of his family and community.



Health may mean devout quality of life, but summarising all this it can be concluded that good health is the foundation of human welfare and productivity.

## HEALTH PROBLEM

Having understood the meaning of 'Health' it becomes easier to outline the problems related to health due to contaminated and unsafe environment. The primary requisites (environmental) for good human health are - fresh uncontaminated air, wholesome water, "fit for human consumption", sanitary living condition, good nutrition, basic immunisation, and primary health care.

Much of the ill health in the under developed countries is largely due to lack of safe drinking water and also insanitary environment. There can be no state of positive community health and well-being without safe water supply. Statistics are not wanting to show that disease rates are drastically cut down by an improvement in the quality of public water supply. In Uttar Pradesh (India), after water works sanitation, the cholera death rate decreased by 74.1%, typhoid fever death rate by 63.6%, the rate for diarrheal diseases by 42.7%. Therefore, money spent on water supply schemes is a sound investment which will pay huge dividends in improved health. In short, the provision of safe community water supply is one of the most effective and permanent health technologies for improving the health of people.

Since, the beginning of the century when international co-operation in public health began, safe water has been a major concern.

Various diseases caused due to contaminated and unsafe water supply and insanitary condition in the environment viz. open-field defecation, open drainage and garbage heaps etc. are spread due to survival of pathogenic organism in the environment and get transmitted and spread due to improper and unsafe handling of water and food. The various diseases are recorded in Table 1.

It is necessary that the rural people should have preliminary information about these diseases with reference to source, mode of transmission, symptoms and nursing care to be taken, so that in case of the diseases occurring in the house hold at least an alarm would be raised and medical aid sought. Otherwise the diseases go unnoticed and unrealised till they assume a serious magnitude. In fact several health problems in the country are associated with environmental health factors, particularly in combination with malnutrition and poverty. The largest single cause of infant mortality in India has been disorders that are closely related to water supply, hygiene and malnutrition.



**Table 1**  
**Classification of Water Related Diseases**

S. Category No.	Disease	Remedy
1. Water borne infections	Typhoid cholera Jaundice Dysentery	Removal of pathogenic microbes, Treatment and Disinfection of water
2. Water washed infections (Skin, eyes)	Scabies Trachoma	Greater Volume of water for use
3. Water based infections	schistosomi -asis Guinea Worm	protection of Source & users
4. Water related insect vectors breeding in water	sleeping sickness yellow fever Malaria, Filaria	water piped from source, cleaning the stagnant water in ditches

**Table 2**  
**Pathogenic Microorganisms Causing Diseases**

Type	Organisms	Disease
Bacteria	Salmonella typhosa	Typhoid, Paratyphoid Enteric fever Gastroenteritis
	Schigella	Dysentery
	Vibrio Cholera	Cholera
Viruses	Hepatitis B	Jaundice
	Polio Virus	Polio
	Echo, Coxackie	Gastroenteritis
Protoza	Entamoeba histolytica	Amoebic Dysentery
	Giardia	Giardiasis
	Ecoli	Non pathogenic but coli indicates pollution
Heliminthes	Hookworm, Round worm, Tape worm, Pin worm, whip Worm	Gastroenteritis Diarrhoea



The other physical and chemical agents present in the environment independent of human activities refer to natural impurities in water such as iron or fluoride contents as well as those pollutants which are introduced into water bodies through effluents from various industries. These are not of common occurrence and have specific reference, hence not dealt with in this presentation.

### **III. WOMEN, ENVIRONMENT AND THEIR ROLE**

Today's crisis facing environment has emerged as a result of its neglect of centuries. It is heartening that there is a new awareness about the peril in which we have already placed ourselves as well as the dangers towards which we are heading. As a result, lot of efforts are being put together to design and plan a concrete approach policy for creating environmentally sound and sustainable development. A significant aspect of such a situation is the realisation about the empowerment of women, half the world's population, in search of a safe environment, economic and social justice and equitable reallocation of resources. It is felt that this alone would lead to a world congenial to healthy and happily living for future generations.

It is now realised that since women's participation in the conduct of daily life is indispensable, their role in defining critical issues and policy making cannot be questioned at the family, community, regional, national and even international level. This becomes more evident when it is understood that sustainable development means,

- finding and using resources that are renewable, and using non renewable resources judiciously.
- using such products which would not harm the environment or the products which are environment friendly.
- respecting biological diversity
- addressing poverty that hinders family planning, taking children as a buffer against the insecurities of the old age by parents

For hundreds of millions of women in the developing world the quality of environment lies mainly in what they are offered as potable water, food and source of energy. The various issues that concern women with reference to environment are:

### **WOMEN, POPULATION AND ENVIRONMENT**

Rapid population growth in poor developing countries is responsible for bringing about permanent changes in the environment. It is felt that by 2000 AD, these changes will reach critical levels of



population growth, inadequacy of desirable infrastructural sources and employment. Poverty and under development are closely linked to environmental degradation.

Women, by virtue of their role as mothers and managers of households have a very close concern with the rapid depletion of natural resources due to gross imbalance between population dynamics and the ecosystem on which the survival and the well being of the people depends.

## **WOMEN, WATER AND ENVIRONMENT**

The majority of women, particularly those in the rural area spend an important part of their time in fetching water needed for their families. If food products are managed most of the time by men, as well as by women, the task of providing water is shouldered by women alone. They need it for drinking and household chores as cooking and cleaning, for children, sick and the old ones in the family. As such women are directly concerned with anything negative altering the quality and quantity of this precious resource. In the developing countries where 80% of the prevalent diseases are water borne the issue, "water safe and fit for human consumption" is the prime concern to women.

## **WOMEN, FOOD AND ENVIRONMENT**

Women as housewives, mothers and protectors of family health assume the critical role of provider of food. Women's role in agriculture is an universal phenomenon. As such, issues related to sustainable agriculture, incorporating waste land development, forest management, techniques of organic farming, hazards of pesticides use, importance of biodiversity and genetic resources and need for new agricultural economies have a relevance of women's involvement in environment management.

## **WOMEN, ENERGY AND ENVIRONMENT**

As managers of households, women's concern with availability of energy resources for cooking as well as lighting is of prime importance for rural as well as urban sector.

Seventy five percent of the world's population depends on biomass for energy needs, fuelwood, charcoal, agricultural residues and dung. Unfortunately although the biomass available could be enough to meet everybody's needs, its distribution varies greatly by region and does not follow population density. According to a FAO forecast, by 2000



A.D. over 2 billion people in developing countries will be suffering from fuel wood scarcity. Assuming that there would be no shifting of roles and women would continue to be the providers of cooked food to families this scarcity would concern the women most.

## **WOMEN, POVERTY AND ENVIRONMENT**

Poverty and environmental degradation are among the most formidable challenges facing the developing countries today. Nearly one third of the population, consequent urbanisation and industrialisation lead to water and air pollution from industries, lack of inadequate shelter, homelessness, inadequate health care infrastructure and lack of clean water. This manifests into poverty due to malnutrition, poor health status, loss of working hours and unemployment. In this context women are the worst sufferers as even today at the end of the 20th century women are not considered as equal partners in the life system.

Poor health of the women, complications of pregnancy and child birth, low birth weight as well as general malnutrition and infection are to blame for globally high levels of new born, infant, early childhood, and maternal mortality. According to world Health Organization(WHO) all these conditional are strongly affected by fertility patterns. They do not occur in isolation but in the context of poor socio-economic situations. With strengthening of education, health and other social services, family planning, through appropriate timing, spacing and limitation of number of pregnancies, the risk of ill health and death for mothers and children can be reduced to a great deal. While delineating women's role in contributing towards keeping environment safe and healthy for themselves, their families and society at large it is necessary to make a special reference to rural women. This is so because their counterparts in the urban area are much more privileged and environmentally literate. The rural women are denied environmental literacy.

The level of literacy and formal education amongst rural people is very low in general and women in particular. As a result women are not aware of basic things which are essential to a healthy and happy living. This, coupled with unhealthy conditions of the rural environment leads to a very poor health status in the villages. As a result our vilages are economically poor, educationally backward and socially disorganised. An important concept that health and environment are interrelated and that for a healthy living, clean environment is a must should be made very clear and understood to the rural women. If this is not done,



the popular beliefs and customs of offering prayers to the deity in case of diarrhoea, dysentery, typhoid and cholera would continue for ever without any concept of cure by medication and prevention by proper care., That, for preventing and controlling gastro intestinal diseases, it is the "Faecal oral cycle of the disease" which is to be broken and offering prayers to the deity will not help to prevent and cure the disease should be made amply clear and correctly understood by the rural women. "How to do this" needs following certain practices with reference to water, sanitation and health in day to day life. Women's role is to follow these and motivate the family members and the community to follow the same. This alone will ensure the good health status of the self, family and also the entire village at large.

## 1. SAFE WATER

People in the developing countries, suffer from water borne diseases because water is of inferior quality and quantitatively also the supply is inadequate. Women and girls may spend many hours each day fetching and carrying water which is poor in quality, simply because it is their only supply, and without it they may die. Provision of clean water closer to homes may reduce the time and energy spent in water collection and may also increase the volume used. Yet, this may not improve people's health. Proper practices in relation to water conservation, collection, storage and use alone will ensure the water as safe and fit for human consumption. These practices are:

1. A safe water supply should always be used. It comes from a source that is protected from contamination viz; a properly installed handpump, or the public water supply through taps. Open sources, such as wells, rivers and ponds, are not safe, because they can be easily contaminated. In case either the hand pumps or the taps are not available and water from open sources alone is to be used, proper care about collection of water and disinfection should be taken.

2. People should be motivated to use handpump water wherever available. It is one of the safest sources of drinking water. Once a proper platform is constructed and the wastewater is drained away, this source is safe. In case of a well, it should be a sanitary well and the rope and bucket for withdrawing water should be clean.

In many villages people refrain from using handpumps and also otherwise treated water (slow sand filter etc), on an assumption that such treated water has an offensive smell and that the cereals are not cooked well in such water. This belief needs to be erased.



3. In case of using water from a river, water from upstream only should be used as it is comparatively free of contamination. Water from open sources should be disinfected by using alum, chlorine tablets or boiling. If fuel is scarce, water can be boiled for infants only

4. Water can also be made safe by adding chlorine and in the village wells pot chlorinators should be used. The local primary health centre should provide information about chlorinating the drinking water in the wells as well as in the households.

5. Water should always be stored in clean containers. Water container should always be kept covered to avoid dirt falling into it. Glasses should not be dipped in to the water. Instead, long handled jug should be used or the water be poured directly into glasses.

6. Long nails on the hand are a potential source of carrying infection. The nails should be always cut and kept clean.

7. People especially the women who knowingly collect drinking water from contaminated sources should be properly informed and encouraged to use protected sources.

8. Reuse of water is very necessary for its conservation. Excess water used in cooking, washing clothes etc. can be reused for watering plants, sprinkling it the courtyard. These things look very simple but conserve water a great deal

9. It is also necessary to turn off the running taps when not in use. Such training to children in particular will take a long way in -conservation of water.

## **2 GOOD SANITATION**

Sanitation is a way of life. It is the quality of living that is expressed in the clean home, the clean farm, the clean business, the clean neighbourhood and the clean community. The term sanitation covers the whole field by controlling the environment with a view to prevent disease and promote health. The factors which have a direct relevance to health are food, water, housing, clothing and sanitation. The safe practices with reference to sanitation are:

1. More than one third of one's life is spent in the house. It is necessary that the house should be kept clean. Sweeping the floor daily and throwing the rubbish in a garbage/compost pit in the back yard keeps the home and the court yard clean.



2. Surroundings of the house should be kept clean. For garbage cow dung and other agricultural waste compost pits should be used.

3. Similarly for wastewater an earthen drain should be built and wastewater from the house should be diverted to the kitchen garden. With the manure from the compost pit and the water from the drain the kitchen garden would give a good harvest.

4. For bathing a simple cubicle should be built and soak pit for the wastewater should be also made.

5. Open field defecation leads to many diseases hence using a sanitary latrine is necessary. Low cost sanitary latrine designs are available and should be used. It is observed that even when sanitary latrines are provided, the rural people do not use them. They have a clear preference for open-field defecation. That open field defecation is the main source of keeping faecal-oral cycle in operation for carrying diseases from one host to another should be clearly made understood to the rural people and they should be encouraged and motivated to build and use sanitary latrines.

6. cattle shed should be away from the house. In the cattle shed the floor should be of stones or brick, sloping towards lined drain. Using cement or lime mortar to fill the joints in the floor and lining the drain connecting it to a soak pit is necessary. In this way animals urine can be drained away. Sweeping the shed regularly and keeping it clean is a must to avoid insanitary condition.

7. Planting trees around the house using wastewater from the household for irrigation keeps environment around the house fresh and clear.

8. In rural areas common fuel used is wood, this leads to enormous amount in smoke which is harmful to health. Using a smokeless chula will prevent the smoke from filling the house because the smoke goes out of chimney attached to the chula. It will reduce respiratory diseases and irritation of the eyes.

### **3. BETTER HEALTH**

The health status of an individual, a community or a nation is determined by the interplay and integration of two ecological universe- the internal environment of man himself and the external environment which surrounds him. In the modern concept, disease is due to a disturbance in the delicate balance between man and his environment.



Of the three ecological factors (agent, host and environment) responsible for disease, the disease agent is usually identified with the help of the laboratory. The host is available for study; but the environment from which the patient comes is largely unknown. Frequently, the key to the nature, occurrence, prevention and control of disease lies in the environment. And since it is the women who are the custodians and managers of the environment in the household, the responsibility of health status of the family lies with them.

For a better health it is necessary to follow certain safe practices as:

1. Household should be kept free of dust and germs
2. Drinking water should be free of contamination water from sanitary wells, hand pumps and taps should be used. Water from open sources should be filtered and boiled
3. Personal hygiene is a key to good health. Hands should be washed with soap before eating. Nails should be always cut and kept clean
4. Sanitary latrines should be used. Open field defecation should be avoided. Household waste (agriculture, animal) should be disposed off in the compost pit; and soak pit; this will also control mosquito breeding.
5. Hygienic practices related to food such as covering the food, washing the food items, vegetables etc. before use, washing hands before cooking, not using stale and spoilt food should be practiced

In addition to these there are other factors relevant to rural environment and need a special mention These are:

- \* Any holes or cracks in the floors or walls of the house should be closed to prevent insects, rodents or snakes
- \* Pesticides should be handled with precautions as: only recommended quantities should be used, measures and empty containers should not be used for other purposes, pesticides should be kept away from the children. After spraying hands and body should be washed thoroughly, crops should be washed carefully before use.
- \* Sickness in the house should be dealt with seriously and medical help, whatever available, should be sought. Domestic medication is harmful.



#### IV AN ENVIRONMENTAL HEALTH PROGRAMME FOR WOMEN

Whether urban or rural, women as housewives play a vital role in home management. Various jobs women carry on are preparing food, collecting water, cleaning house and surrounding area and looking after the children and the sick. In brief, besides being a housewife a woman is a manager of the household, educator of the children, protector of the family health and mainly the motivator of the family's health behaviour pattern with reference to knowledge, attitude and practice.

In the rural area women are burdened more due to the prevailing unhealthy environmental condition in the villages viz, scarcity of water supply, insanitary conditions in the surroundings, and lack of education, medical and communication facilities. At times, in addition to this women have to bear the burden of providing the basic needs and supporting the entire family due to the various malpractices such as alcoholism, drug abuse, depression, violence etc.

Availability of adequate water, is basic to life and has a crucial role to play on health of people since many of the diseases are water-borne. Fetching and carrying water is one of the important chores of women especially in rural areas, and with depletion of water resource this is becoming a drudgery for women, who have to spend several hours on this activity. Often the water procured with hardship gets polluted during transportation and storage due to ignorance of right practices. In addition to drinking, water is needed for cleaning. Often the water thus used causes insanitary conditions due to improper drainage. Such contaminated and polluted water source, (surface and ground water) often becomes the major cause of epidemic and water borne disease. On the other hand inadequate water availability is also responsible for poor sanitation. Hence, it is important that women, especially in the rural areas, are made aware of the linkages between water, health and sanitation and few women leaders in the locality are also trained to play an active role in the adoption of relevant practices and technologies in their area and community. With this in view it was decided to organise three environmental awareness camps with specific reference to water, sanitation and health in the selected villages.

For this purpose suitable integrated models have to be developed and field tested in different parts of the country for replication and achieving the necessary spread effect. This project was hence formulated and sponsored as an All India Coordinated project by Department



of Science & Technology, New Delhi for covering different agroclimatic regions so that problems specific to these regions can be taken care of.

As a part of this project in the western zone of the country nine tribal & interior villages in Hingna Tehsil of Nagpur district were selected for maximum benefit to the rural women as desired and this programme has been carried out by NEERI, Nagpur.

As regards these nine villages, the demographic structure as well as other information pertaining to water, sanitation health status at the above reveals :

**Table 3: Demographic Structure of the Project Villages**

Sr. No.	Name of Village	Area of village in hectares	No. of occupied residential houses	(Total population (including institutional & houseless population))			Schedule caste		Schedule Tribe	
				Total	M	F	M	F	M	F
1.	Dabha	433.72	103	503	257	246	27	31	42	48
2.	Agargaon	453.58	85	542	311	231	-	-	60	46
3.	Yeangaon	485.91	91	460	236	224	-	-	210	192
4.	Degma	800.12	95	447	222	225	-	-	118	126
5.	Kokardi	275.11	22	113	51	62	-	-	44	58
6.	Mathani	426.06	20	118	56	62	-	-	37	49
7.	Pipaldhara	715.96	99	497	245	252	11	6	104	109
8.	Madaodhra	499.83	43	244	125	119	-	-	86	82
9.	Katanghara	391.30	61	325	172	153	-	-	72	67
Total				3249	1675	1574	45	44	773	777

**Table 4**

**Distribution of Scheduled Caste and Scheduled Tribe Population**

Villages	Population	
	S.T.	S.C.
Dabha, Agargaon, Yeragaon	40%	12%
Degma, Kokard, Mathani	64%	-
Pipaldhara, Katanghara	49%	4%
Mandaodhra		



**Table 5**  
**Literacy Amongst Women**

Village	Total Res-pondents	Literacy amongst women				
		upto Primary	middle school	high school	college	Illiterate
Dabha	39	8	7	2	-	22
Agargaon	38	10	3	-	-	25
Yerangaon	25	3	6	-	-	16
Pipaldhara	43	14	2	-	1	26
Mandaodhara	28	5	1	-	-	22
Katanghara	12	2	-	-	-	10
Degma	42	6	5	2	-	29
Kokardi	14	-	-	1	-	13
Mathani	16	3	1	-	-	12

- \* No organisation like mahila mandal, mahila sadhan are existing in these villages. Adult education classes are held in villages, Dhabha and Yerangaon
- \* Most of the residents being poor are having kutcha houses, viz. 97.27% Rest of the houses are semipucca
- \* No latrines are available in the villages, open field defecation is the common practice
- \* No organised system of drainages has been observed in the villages. The wastewater is either absorbed naturally in the soil or stagnation of water is observed showing insanitary condition of the villages
- \* The source of drinking water is mainly open dug wells. Only villages, Katangdhara, Pipaldhara, Degma are not having hand pumps, all other six villages have handpumps. In Dhabha, along with the handpump a borewell is also used for drinking purpose. In Degma there is a water tank which is damaged. Pipaldhara has a well for drinking water, it is dried up in summer. There is a river in between the villages Kokardi and Mathani which is entirely dried up in summer.

The morbidity survey revealed that water-borne diseases are reported only amongst 40 males, 28 females and 98 children, mostly complaining of gastroenteritis, dysentery and diarrhoea. On the contrary our visual observation however, revealed very poor health status.



As regards the information about other major diseases like malaria, T.B., Small pox, etc., only 3.8% people have reported malaria, Filaria, pain in abdomen, some dental problems and asthma. There is no medical aid available within 5 Km distance.

Besides this, an educational diagnosis of the women in these villages was undertaken to understand the extent and nature of knowledge amongst the rural women on water sanitation and health practices. This helped in formulating the awareness programme-software and hardware for the camp viz. emphasis on withdrawing water with a handled mug, constructing compost pit and soak pit in the courtyard, personal hygiene, child nutrition etc. six women from each village were selected in consultation with local people and these women attended the camp. These women after the camp are supposed to go back to their villages and work towards environment awareness and creating a cleaner, safer and healthier environment in the village. The camps were held for 3 days duration at Dabha, pipaldhara and Degma.

The contents of the camps refer to:

- a. Group discussion and talks on the following topics
  1. Environment and human life
  2. Environment & rural sanitation
  3. Water purification and proper storage
  4. Water borne diseases & their transmission
  5. Personnel hygiene and its impacts on health
  6. Biogas and its use
  7. Community participation and environmental awareness
  8. Child health, nutrition & environment
  9. Women and environment
- b. Educational aids related to water, health and sanitation
  1. Charts and flash cards with slogans
  2. Slide show
  3. Educational games & puppetry
  4. Demonstration of latrine, soakpit, compost pit, pot chlorinators and chlorine tablets and pilot units construction
  5. Impact evaluation in project villages after the camps



For the impact evaluation, following criteria and indicators were used:

1. Change in KAP of the camp inmates with reference to
  - a. Use of water- cleanliness around the source, methods of with drawing water, potability, methods of purification, storage and handling practices
  - b. Sanitation - why use latrine?, faecal oral cycle, drainage, disposal of garbage, compost pit, soak pit
  - c. Relation between: health and environment
  - d. Water borne diseases with reference to source, mode of transmission, and control measures
  - e. Child health and nutrition

Besides this, preparedness to come together as an identified group as Mahila Mandal to hold development programmes such as organising balwadi for village children, co- operative group for income generation, taking up 'clean the environment' drive in the village etc. was also judged.

2. Behavioural changes in the camp inmates after attending the camp - visual observation. This has reference to
  - a. Extent and nature of communication amongst camp inmates themselves
  - b. Removal of inhibitions and preparedness of some of the camp inmates to come forward to the dias and talk
3. Study regarding the approach towards installation and use of the latrine, soak pit and compost pit
4. Action taken by the women camp inmates to start some activities in the village by motivating the other women in the village.

## **IMPACT EVALUATION**

The impact evaluation revealed that general awareness about environmental cleanliness has increased, concepts about, source, mode of transmission and remedy for various diseases are more clear and there is increased appreciation between environment and health. These observations are with reference to :



## A. KNOWLEDGE - ATTITUDE - PRACTICE (KAP)

There are certain points about which the camp inmates were not at all aware and had negligible or no knowledge. There were certain points about which the camp inmates had some knowledge, either wrong or right. This was revealed in "Educational diagnosis" referred to above. After the camp there was a definite change in the KAP and awareness as

\* Before the camp, women could not specify the unhygienic conditions around the water source in their village. After the camps specific answers were given as-

Total No. of respondents	No of respondents stating condition of water source as			
	Surrounding not clean	Stagnation of water around	Foliage around the well	Surrounding clean
56	16	30	4	18
%	28.27	53.27	53.57	7.14

\* As regards awareness about hygienic condition around the water source

Total No. Of respondents	No.of respondents saying			
	Surrounding be clean	There should be no stagnation of water	There should be platform around the well/ hand pump	There should be a channel platform
56	22	11	31	23
%	39.28	19.64	55.35	41.07



- \* As regards potability of water from the source in the village, water was reported as potable both before and after the camps. The apprehension is that since there is no alternate source and water is rather scarce whatever source is available has to be accepted as potable
- \* Before the camps the women said that they did not know whether bleaching powder was put by the Gram Panchayat in the well in the village. After the camps, 78.57% women said that bleaching powder was put in the well and 21.52% women said that the purpose of bleaching powder was to remove contamination from the water
- \* After the camps 60.71% women said that they stored water in pots with large mouth so that they can be cleaned properly. This concept was not clear before the camps
- \* Before the camps, all women said that they used glass for withdrawing water. After the camps 65.5% women reported that they used mug with handle. Query as to why they use mug with handle revealed, 66.7% respondents said that this method is safe, but 51.77% respondents specifically mentioned that this way water does not get contaminated
- \* Before the camps only method of purification of water was reported as straining through a piece of cloth. After the camps they have understood other methods of purification as

78.57% know about use of bleaching powder, alum

19.64% know about use of chlorine tablets

32.28% know about the boiling water during epidemics

Query whether they are following any of these methods revealed:

87.71% are practicing either of these methods for purifying the water, whereas 14.28% still have certain inhibitions, taste of water getting spoilt etc. and they are not following any of these. They still do only straining through cloth.

\* As regards disposal of garbage from the house, before the camp, respondents said that there was no organised system and all the garbage from the households, was thrown on the outskirts of the village and such heaps were actually observed by us. They had not heard anything about the compost pits which could be made in the courtyards, using the compost for kitchen garden etc. After the camps



96% of the camp inmates said that they will start such compost pits and some of them have already started such pits now. Why compost pit? revealed following answers

1. For manure- 33.92% respondents
2. For proper disposal of garbage so that it is not scattered 37.5% respondents
3. For mosquito control-17.65% respondents
4. No answer- 10.73% respondents

This means that concept that compost pit gives manure has not been properly understood by all and it is necessary that more efforts need to be done

\* Similarly about disposal of wastewater before the camps all inmates said, they discharged it on the ground and it goes to some drain flowing near by. After the camps the situation is:

- discharge of the waste water to

1. Open field by 75% respondents
2. Drainage by 8.72% respondents
3. Soak pit by 16.07% respondents

The concept of soak pit is not clear and preparedness to make and use soak pit needs more efforts to make it understood

\* All the inmates uniformly stated that they had no latrines and went to open fields for defecation. Water seal latrine (NEERI design) have been put up as demonstration units in the camp-villages and after the camp, inmates expressed enthusiasm and readiness to have the latrines, provided, they are given some financial aid

\* As regards knowledge about diseases following observations were made before and after the camps-

1. general awareness about common prevailing diseases, Dysentery, Diarrhoea, Typhoi, Cholera, Malaria and Filariasis (Few cases of filaria were observed in some villages) and their cause, mode of spread and transmission, symptoms etc. -% of correct answers before and after the camp from camp inmates are as



Villages	Dysentery		Diarrhoea		Typhoid		Cholera		Malaria		Filaria	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
1. Dabha	20	40	Nil	40	Nil	-	Nil	40	Nil	40	Nil	30
2. Agargaon	6	80	Nil	80	Nil	-	Nil	80	Nil	80	Nil	20
3. Yerangaon	Nil	75	Nil	75	Nil	-	Nil	75	Nil	100	Nil	100
4. Degma	Nil	60	Nil	50	Nil	-	Nil	60	13	100	Nil	60
5. Kokardi	Nil	80	Nil	75	Nil	-	50	100	Nil	40	Nil	60
6. Mathani	Nil	20	Nil	50	Nil	-	Nil	20	Nil	100	Nil	20
7. Pipaldhara	Nil	50	Nil	60	Nil	-	Nil	50	30	100	Nil	50
8. Madaodhara	Nil	75	Nil	80	Nil	-	Nil	75	Nil	100	Nil	75
9. Katanghara	Nil	50	Nil	20	Nil	-	Nil	50	Nil	100	Nil	50

\* As regards the relation between health and environment and health practices following observations were recorded

Cause of the disease	% of respondents	
	Before the camps	After the camps
Lack of clean potable water	3.72	96.42
Lack of clean surrounding	Nil	91.07
Open field defecation	Nil	28.57
Improper drainage	Nil	91.07
Imporper disposal of garbage	Nil	46.21

As such it is clear that concept of faecal-oral cycle was not at all known to the women, the camp inmates and after the camps there is some awakening in this regard :



As regards Awareness about personal and environmental hygiene for prevention of diseases following observation were recorded:

Replies from the camp inmates after the camps	% of respondents saying
Keep the household clean	100.00
Keep the court yard clean	37.50
Cut the nails and keep them clean	28.57
Wash the hand clean and ask others in the family to do so	30.50 71.42
Wash the utensils clean	
Use safe water (after purification)	75.00
Proper storage and usage of water	91.07
Use clean clothes and Keep personal hygiene	51.78

Query as to what they would like to do in the village for keeping diseases away by way of adopting various measures introduced during the camp revealed information as.

Measures to keep diseases away saying	% of respondents after the camps
Keep the area clean	48.21
Platform around the water source	32.14
Disinfection of well water	26.78
Use of wasterwater for tree plantation, kitchen garden etc. to avoid stagnation of water	76.78

As to adoption of new technologies introduced in the camps and whether they would like to adopt them, the faourable answers were given as:

Regarding construction of latrines, the women are ready to take up this facility provided some monetary aid is given. Scarcity of water is also one factor which keeps the women away from thinking of using latrines.



37.5% women could make soak pits for their households. This, they feel would control stagnation of water and mosquito nuisance.

23.21% women are desirous of having compost pits in their court yard. In fact these women have started efforts towards making soak pits and compost pits.

## B. BEHAVIORAL CHANGES

The women, when they attended the camp on the first day were rather reserved, keeping to themselves and keeping generally quiet observing the proceedings with restraint. As the camp progressed they started talking, discussing, relating their experiences, difficulties and inabilities to do certain things due to various restraints, inhibitions in the village atmosphere. Those women, who, when asked to come forward and tell their difficulties to the chief guest, the state officials, B.D.O, Tahsildar of the block, but did not do so feeling rather different and shy. At the end of three days, in the concluding session, they came forward and put up their grievances, complaints with enthusiasm. The state officials present on the occasion were very happy about it and promised to help them out. This is as :

Question pertaining to	% of respondents giving correct answers
Personal hygiene	71.42
Proper method of water collection	98.21
Proper sanitary measures	80.35
Awareness regarding healthy environment	21.42
Child care and nutrition	71.42
Leadership qualities	16.07
Initiation of some projects related to village environment	39.28

Mahila Mandals are being formed in these villages and help for the registration etc. is being given by the B.O.D's office.

It is thus clear that there has been a positive impact of the project on these women with reference to awareness generation.

However, there are various constraints, mostly the financial ones for the follow up on their own initiation for using the technologies. As regards the knowledge about the measures they have to adopt and



practice it on personal level, it has reached the women, if not to all, to a fairly good number and it is felt that with some new incentives and encouragement, desired benefits can be achieved.

## IMPEDIMENTS

Such environmental awareness camps for rural women would lead to desirable change in KAP, has been proved by impact evaluation exercise. It is also proved that the women so motivated would like to use the rural technologies to make their villages clean and free of diseases. However there were many impediments which were experienced during the camps as-

- \* Initially it was very difficult to communicate with these rural women because of inhibitions on their part to come out openly and talk.
- \* There was lack of enthusiasm and an apathy towards any such programmes. This may be attributed to illiteracy, to some extent to poverty and also to previous bad experiences of promises unfulfilled by the Government.
- \* There is no priority for such programme in their routine life as women are amply busy with routine domestic work as well as earning chores, farming etc.
- \* There are no social organisations such as welfare committee, Mahila Mandal, co-operatives etc. which could be used as platform for motivating the women to participate in this programme.
- \* The project villages are distant and in interior making it difficult for us to keep constant contact with the village women for desired communication. There should be more funds towards travel.
- \* The funds provided in the project were just enough to organise the camps and no continuous efforts could be put up for sustaining the interest aroused.
- \* We have constructed water seal latrine and one soak pit each at the camp sites i.e. three villages. It would have been more appreciated if we had these units in all the villages from where the camp inmates were selected



The project is successful in generating awareness amongst the camp inmates. However, sustainance of this would depend on repeated visits, continued efforts and also provision of tools for follow up action. The limited allocation of funds does not allow this. However an effort is made to initiate some voluntary organisation in the city to use this "awareness" and take up environmental developmental projects in these villages which were so far neglected. Besides this women alone cannot make these programmes successful resulting in the 'clean the environment' project in their villages.

It would have to be a co-operative venture, or otherwise some would clean the environment and others would continue to make it dirty.

Various constraints in achieving this would be:

1. An apathy of the rural people in general towards accepting such technologies viz. making soak pits, building latrines, afforestation etc.
2. Purposeful non-cooperation by some unfriendly groups
3. Lack of financial resources. People may not like to spend on providing and utilising these technologies, without which they were living in the village for generations.
4. Destructive activities of some nuisance causing elements in the village.

## **V. RECOMMENDATIONS**

After having conducted these awareness camps following recommendations for desired success are made:

Overcoming all the constraints and ensuring acceptance and implementation of desirable KAP and technologies by rural people in general and women in particular would need 'Effective Community Participation' programmes.

By effective community participation, it is meant that if a programme, say building soak pits in the village, is launched, every household should participate in the programme. Or in other words, it should be a programme of the community, for the community and by the community.

Such programmes need to be initiated and carried out effectively. For initiation effective leadership is necessary. In the camps, an effort has to be made to develop this understanding and also develop



leadership qualities in the camp inmates. These identified leaders can bring the community together and launch the environment development programmes in the village.

The education material and aids to be used should be appropriate to the situation and interesting to lead to desired effect.

## **VI. CONCLUSION**

The very purpose of any development programme is uplifting the quality of life {QOL} of the people under consideration. Health is a primary parameter determining the QOL and need to be dealt with as a priority. Awareness amongst women is a 'must' as a woman is the manager of the household, educator of the children and protector of the family health. Key to success toward Improved quality of life by keeping environment safe and healthy is to make women environmentally literate. The rural people are deprived of basic amenities. The rural women, unfortunate as they are, also deprived of environmental literacy. This makes their life very unhappy and unhealthy. Efforts to generate environmental awareness and providing appropriate rural technologies would definitely improve the Quality of Life for the rural people at large.



# MOBILIZING THE PEOPLE FOR EPI THE BANGLADESH EXPERIENCE

*Mahboob Shareef*

## INTRODUCTION TO BANGLADESH THE COUNTRY

Bangladesh is a country of nearly 115 million people occupying approximately 150,000 sq. Km. making it the most densely populated country in the world. The annual growth rate of 2.2% will result in a doubling of the population in about thirty years.

The country is divided into five administrative divisions with a total of 64 districts; these districts are in turn, divided into 460 sub-districts (thana), 4,334 unions, 14,376 wards and 85,650 villages.

## HEALTH STATISTICS - MATERNAL AND CHILD HEALTH

3.2% of the total population comprise children under one year age. The infant mortality rate is estimated to be 91 per 1000 live births and the child mortality rate is 134 per 1000 live births. 600 women die from complications linked to child birth or pregnancy for every 100,000 live births. 66% of children under the age of five, suffer from malnutrition. 50% of infants are low birth weight.

**Health infrastructure** Medical college hospitals located in major cities and towns provide specialized treatment. At district level, there are modernized hospitals as well as maternal & child welfare centers. Most of the thanas (sub-district) have health complex each of which serve an average population of 200,000. About 3,400 union have either a Health & Family Welfare center or Rural Dispensary each providing outpatient care to about 25,000 people. Each has at least one Health Assistant and one Family welfare Assistant who are domicillary workers. In addition, there are 108,000 EPI outreach sites and over 30,000 satellite clinics for community level MCH and Family Planning service delivery.

## SUCCESS IN CHILD SURVIVAL AND DEVELOPMENT EFFORTS

Bangladesh can boast of a few extraordinary achievements among modest progress in general.

---

*Mahboob Shareef, Programme Officer, EPI, H&N Section, UNICEF, Dhaka*



Over 80 percent of the population now have access to safe drinking water, making Bangladesh one of the few South Asian countries to achieve the Water Decade target.

A decisive step has been taken to combat the high prevalence of iodine deficiency disorders by enacting a legislation to make the iodation of all edible salt mandatory.

Compulsory primary education was introduced form January 1992 with free education being provided to girls up to class VIII in rural areas.

In the fight against vaccine-preventable diseases, Expanded Programme of Immunization (EPI), achieved a phenomenal increase in immunization coverage from less than 2 percent in 1985 to more than 70 percent in 1992. Vaccination service accessibility has reached to more than 90 percent. The latest coverage survey jointly conducted by the Government and Donors showed that of children aged 12-23 months, 92percent had received BCG,82 percent three doses of OPV and DPT and 76 percent Measles vaccine. 82 percent of pregnant women had received 2 doses of TT. Drop out rates for multiple-dose vaccines have shown a significant decline suggesting that parents are increasingly becoming aware about the need for complete protection of their children.

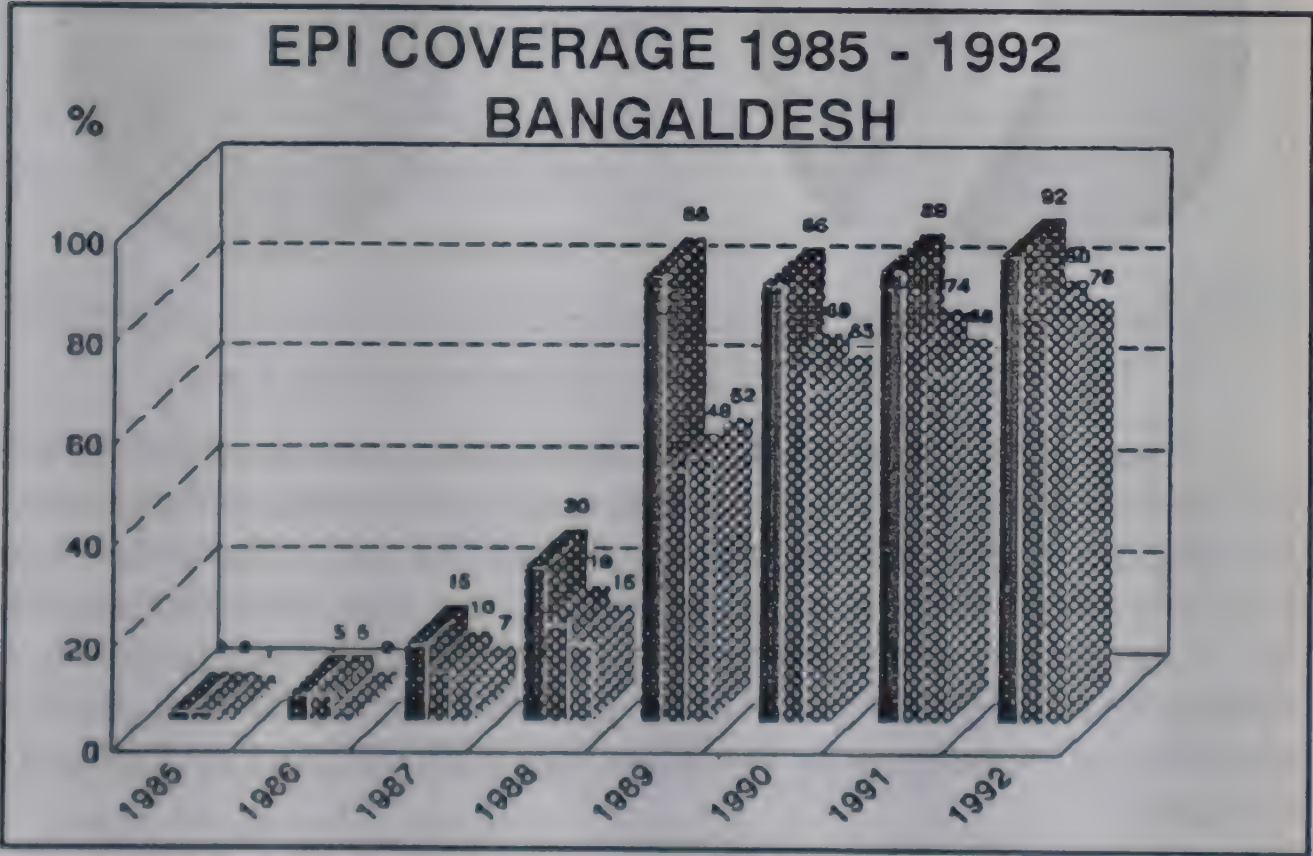


Figure 1: Increase in EPI Coverage in Bangladesh 1985-1992



# PROGRAMME STRATEGY TO ACCELERATE THE EPI COVERAGE

The government launched the EPI in 1970 to provide services from static and fixed health center and reached only 2 percent of the target group by end 1985. Then the national commitment to reach UCI target (of 80%) came. To achieve this ambitious target new strategy was introduced. By adopting the outreach site strategy the government took the unique step to take health service facility out of the health center. The service reached the door step of the villagers who were asked to participate in their own health delivery system.

To ensure the availability of immunization services within one kilometer radius of all beneficiaries, in each ward 8 outreach sites were identified and established by the community at a central point of the catchment area.

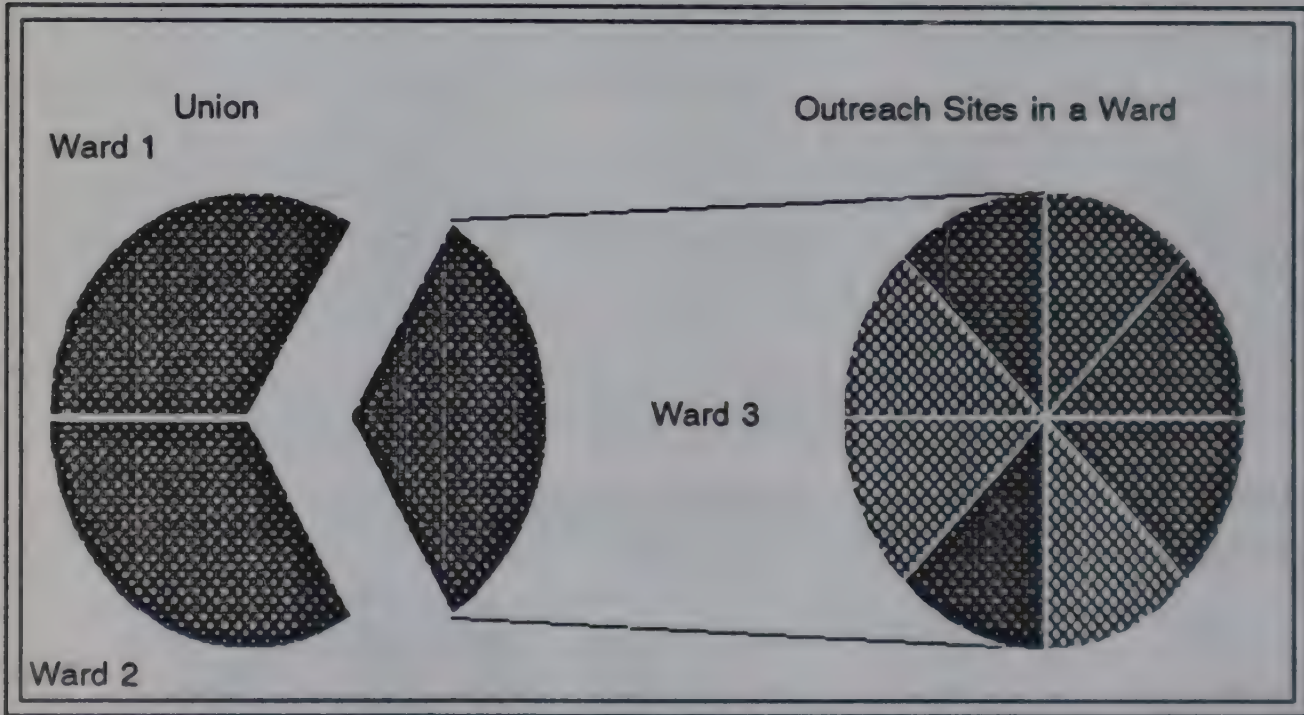


Figure 2: Setup of EPI outreach sites at the Ward level

These sites (popularly known as outreach site) Is visited by the vaccination team (Health Assistants and Family Welfare Assistants) monthly on a pre-determined day known to the community. The sessions are attended by children aged up to 1 year, pregnant women and women aged 15-45 years. Vaccination teams have a registration system that identified each child by site (blocks) for vaccination services and subsequently identifies new born, dropout and left outs by name.



## **MAJOR EVENTS CONTRIBUTING TO THE SUCCESS OF EPI PHASED EXPANSION**

For the purpose of universalization of services throughout the country, the philosophy of "start with the possible and build on success" was followed. Intensification of activity was implemented in phased manner. This phased expansion helped in modifying the work procedures and strategies on the basis of experiences gained.

### **POLITICAL WILL**

The Ministry of Health & Family Welfare realized that health system alone does not have the human resources and skills to undertake the difficult task of increasing and sustaining the demand for immunization. Following the intensification of EPI, emphasis has therefore been placed on generating community support for the programme.

The prime responsibility for assuring community support for immunization services naturally fell on the political leaders. At national level, the Head of the State personally committed and made the Government's commitment public several times. The succeeding Prime Minister also signed a declaration pledging her government's support for the achievement of disease eradication, elimination and reduction targets for 1990s. Political leaders at different tiers were active to mobilize the people in support of EPI.

### **INVOLVING THE CIVIL SOCIETIES ORGANIZED GROUPS/BODIES**

Very soon, however, the realisation came that political will, outreach net work and the availability of low cost technologies are not enough to accomplish a child survival and development revolution. Planning for programme implementation must be put at the people's disposal. Therefore, involvement of community, local government council/elected bodies and NGOs and service clubs are equally important. Community involvement helped to generate demand for vaccination from parents.

For this to happen, a movement was created for EPI, whereby a great number of partners came on board, committed to a common goal. There are many unsung heroes and heroines of this movement who are still working hard for this common cause, day in, day out. They are the Mothers of Fully Immunized Children (MOFIC) who motivate



other mothers for timely completion of their children's vaccination. They are the health and family welfare professionals, the Union Parishad Chairmen, the organized women's groups (such as Grameen Bank), the women teachers. They are the members of Rotary, BRAC, CARE and other social clubs.

The most important allies of the programme are the common people who have volunteered to let their homes be used as EPI outreach sites and come forward to assist government health and family planning workers in bringing the target population to sites. They are popularly known as Outreach site Care Takers (ORSCT) and have been oriented so that they can become an agent for change in the village, motivating neighbours to vaccinate their children.

## **MEDIA SUPPORT**

And in the drive towards disease eradication in the 1990s, a partnership has been built with all sectors of the mass media both traditional and modern, with artists and entertainers, community and religious leaders, service clubs and professional societies, sports and youth organizations as well as non-government and voluntary bodies. Accordingly, allies were brought 'on board' EPI bandwagon in order to create a social movement for immunization.

The introduction of child survival effort through EPI created an atmosphere which not only encouraged journalists form a network but encouraged an environment of learning and exchange. The structure of the EPI was rural based and decentralized; therefore, media support was shifted from the capital to the country side to include a regional and community focus to allow the mobilization of communities throughout the country.

In addition, mass media communication through television, radio, newspapers, wall painting, billboards and posters have been widely diffused. Leaflets, booklets and flip charts have been made available at all levels.

## **NGO SUPPORT**

In Bangladesh, NGOs have a strong field presence and intimate contact with the population. NGOs were encouraged to move into relatively low performing areas to support government staff in the management of outreach sites and the promotion of increased awareness about and demand for vaccination among parents. Most of the major NGOs like ADAB, VHSS, BRAC, CARE came forward to help government. Rotary has been a partner since beginning of the pro-



gramme. While funds for polio vacciness came from the Rotary International, the local rotary clubs were actively involved in social mobilization activities.

## **INVOLVEMENT OF CELEBRITIES**

Star value was added in different ways. UNICEF special ambassador for Sports international cricket star Imran Khan, UNICEF Good will ambassador world renowned film star Audrey Hepburn, internationally renowned Indian cricket star Kapil Dev, the captains of two rival football teams of Bangladesh posed for posters and moved to different parts of the country to talk about EPI with cross section of people. All these efforts gave EPI a high visibility and immediate recognition.

## **LOCAL LEVEL ADVOCACY MEETING**

A standard approach was developed to allow involvement of local administration. District and Thana followed by union level advocacy meetings were held with different government departmental heads, voluntary organizations, professional associations and community leaders to finalize detailed plans of action.

## **NATIONAL IMMUNIZATION WEEK**

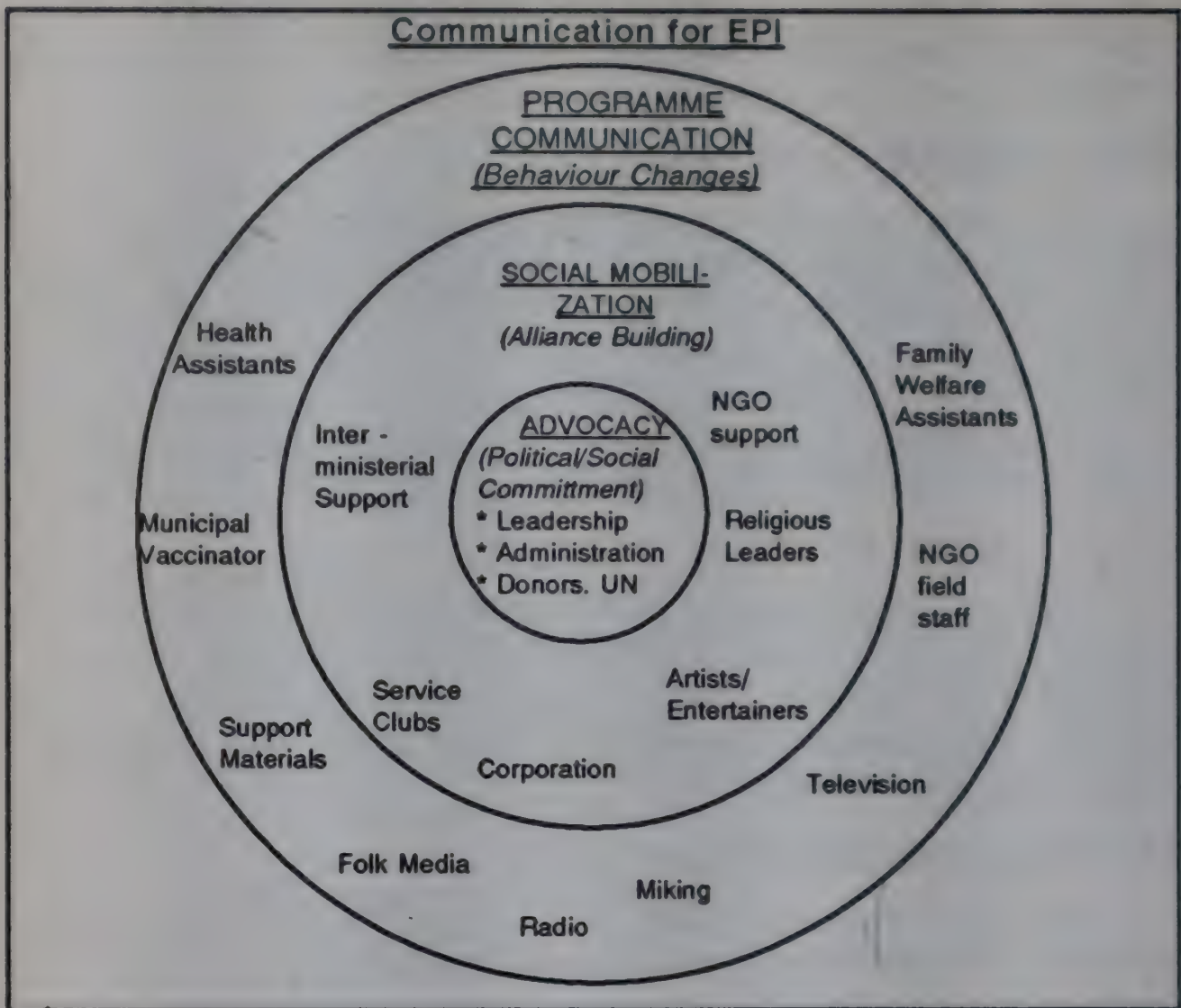
Seven EPI intensive weeks and days have been observed nationally with the involvement of internationally known sports personalities. Community theater groups organised street shows in different parts of the country supporting immunization. These programmes have included a wide range of cultural and entertainment programmes with a strong visible impact on large sections of the community. During the National Immunization Week (NIW) NGO and government field workers tracked new borns, drop out and left out children and subsequently arranged their vaccination. Recognition events were organised to provide awards for those who have contributed in reaching target.

## **COMMUNICATION STRATEGY**

For the purpose of effective social communication, three main strategies were adopted from the beginning of EPI intensification:

1. Advocacy, to gain social-political commitment ;
2. Social mobilization, to bring on board a large number of social allies for demand creation, training and service delivery; and
3. Programme communication for delivering specific programme messages and strategies aimed at sustained behavioral change.





## MONI LOGO

One of the first elements of the communication programme was the search of a symbol which people would recognize and understand easily. Since 'MONI' is a term of endearment for children of both sexes, a character was drawn to suit the term. Six arrows, symbolizing the six immunizable diseases, and a ring, symbolizing protection, were added. EPI and the 'MONI' logo have become household words and visible symbols throughout Bangladesh evidence of a high level of awareness countrywide.

## DECENTRALIZATION PROCESS

Decentralization of resources coupled with local plans of action have given confidence and flexibility at sub national level to plan as well as execute programmes effectively and rapidly. Provision of funds at the disposal of local authorities have helped to cover recurrent expenses and respond to local needs.



## **PROGRAMME MONITORING FOR BUILDING CONFIDENCE**

The linkage of mobilization with effective vaccination services was the key to success. Regular feedback on performance, joint activities of health and family planning staff and intersectoral support helped assure regular provision of outreach services and achievement of session targets. Functional committees from national down the thana level were active to regularly review progress and provide guidance in overcoming implementation constraints.

To assess the actual vaccination coverage status coverage evaluation survey is being conducted every year under the supervision of donors and NGOs. This kind of annual independent survey on regular interval creates trust among the donors, political leaders, media people and field workers.

## **BUILDING ON SUCCESS**

The inspiring example of success in EPI provides a confidence to those involved in development fields in an atmosphere where despite generous development investments, targets have fallen short in many sectors: industry, health, education, social welfare, and family planning. But EPI can be made even more successful, and it must! There is a need to increase the immunization coverage among under ones by reducing drop outs and increase service accessibility to the population living in hard to reach areas.

The process of immunization involves 15 million contacts each year with mothers and infants. A pragmatic programme has been developed to utilize these EPI contacts with mothers and children in order to provide a wide array of additional essential services, in line with the EPI Plus approach, including vitamin-A, iron supplementation, contraceptives, oral rehydration, growth monitoring, deworming and safe motherhood.

Much has been achieved. Many partners have been energized. That energy must now be maintained until parents want immunization for their children as they want food, clothing and shelter.



# ROLE OF WOMEN IN DECISION MAKING PROCESS:A CASE STUDY ON UTILISATION OF PRIMARY HEALTH SERVICES IN MADURAI DISTRICT

*Dr. J. Prabhu Clement Devadoss*

## INTRODUCTION

Most of the decisions made in our societal milieu is through small group of people. How good the decisions are depend on how good these small groups are effective. Women have been identified to promote health and development of her family through her constant interaction with family members. "Patterns of interaction" is governed by various factors that influences the family members during illnesses and due to pressing problems in the vicinity of the family. With these internal interaction other external forces may influence or may have the impact on the process of decision making. When sick, especially when her own child is suffering from diarrhoea or acute respiratory illness with cough and cold, the mother's quickness in reaction and interaction with family or with other external agencies and making a decision on the treatment is very vital particularly availing the primary health centre services.

## WHY THE STUDY

The purpose of decision making is to decide upon, well understood, and realistic action toward the well being of the members of the family. Do the mothers understand and realistically act? Do they have an alternate course for their action, like home remedy, traditional treatment etc. etc.

There are several reasons for indecisiveness:

1. Resource-availability to be used or not to be used
2. Time - oriented decision
3. Objective - oriented decision
4. Hirsutic bias - based on past experience
5. Uncertainties & risks

---

*Dr. J. Prabhu Clement Devadoss, Deputy Director Health Services,  
6, Ramamurthy Road, Chinna Chokkikulam, Madurai-625002*



6. Fears and conflicts
7. Economic situations
8. Social factors & cultural dimensions
9. Information and knowledge of mothers

These are the major problems in the rural area to take decision to use the P.H.C. services. It is interdisciplinary as it includes social, cultural, psychological and other variables. The major problem is on the awareness of facts and the attitude of women.

## **OBJECTIVE**

To assess the perception of decision making process among the women in utilising or not utilising the health service and identifying those factors influencing in this process.

To assess the "self" decision taken by the mother in utilising the illness condition and in using simple remedial practices.

To assess the quality of the correct decision and the timeliness.

## **METHOD**

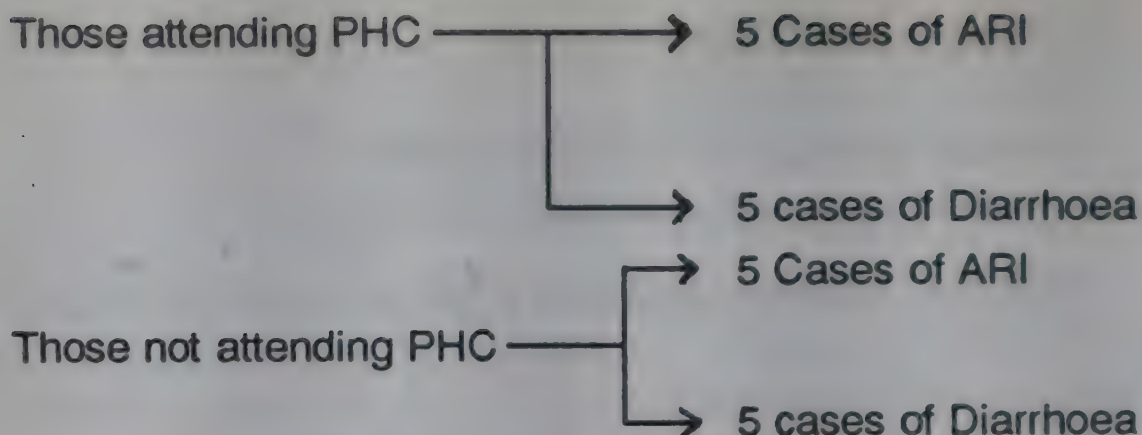
The study was taken in Madurai Health Unit District with reference to the factors influencing the mothers to bring their children to the primary health centre for immediate perceivable illness.

It is an interview type of questions. The questionnaire is developed and field tested before use. There are two sets of questionnaire identical for diarrhoea and acute respiratory illness. The mothers of children with diarrhoea or ARI who are less than 5 years of age are questioned. These mothers when they attend the P.H.C. during O.P. hours between 8.00 am to 11.00 am, are questioned and the findings are recorded. Later a door to door enquiry is taken up to identify children of the same age group and with same type of illness but have not come to the Primary Health Centre.

## **MODE OF SURVEY**

A selective band of social science graduates' and health supervisors are used for collecting the information. They were trained by Director of Gandhigram Dr.M.B. Soudarssanane who is also the guide for this study. An interviewer has to collect data from those attending PHC and those not attending PHC.





(Total 20 Cases: 10 PHC -10 in field)

The duration of the study and the time of study was during October 1993 and November 1993 spread over a period of 60 days and on purposive selective days these interviewers visited the PHC and its headquarters villages.

PHC is one where medical facilities are available and where qualified doctors render their services and the field or the study population is from the same headquarters village or the nearest village, not beyond 2 Km.

## SAMPLING

Of the 11, 59, 980 total population, the under 5 population is around 1,44,875 (12.15%).

A purposive selective sampling of 150 diarrhoea cases and 150 ARI cases among children under 5 Years of age is taken up for the study. Out of 31 P.H.C.'s a randomly chosen 15 PHC's are taken to collect data from those attending the PHC and from those not attending the PHC.

Total Population Rural Area	11,59,980
Population under 5 years(12.5%)	1,44,875
Estimated diarrhoea among them 1% in a year	1,448 cases
Estimated ARI among them 1.9%	2,752 cases
Sample of diarrhoea cases	150
Which is 150/1448	10.5%
Sample of ARI cases	150
Which is 150/2752	5.4%



## RESPONDENT

The respondents, the child's mother are of different age group and have children in different age groups. 80% of mothers who participated in the study are between 20 to 30 years of age.

The respondents according to the age of the child are as follows.

**TABLE I**  
**MOTHER'S ACCORDING TO CHILD'S AGE**

Children age in months	Mothers age (In Years)					%
	PHC ARI	ADD	Field ARI	ADD	Total	
0 - 6	15	12	10	13	50	13.5
7 - 12	19	26	20	28	93	31
13 - 12	16	20	20	19	75	25
25 - 60	25	17	25	15	82	3
Total:	75	75	75	75	300	--

Further extraneous factors of influencing the decision process is literacy and the respondent literacy status is as given in Table II. The illiterate mothers are 41.7%

**TABLE II**  
**LITERACY STATUS**

Literacy status	PHC		Field		Total	%
	ARI	ADD	ARI	ADD		
Husband literate	54	56	62	11	233	77.6
Husband illiterate	21	19	13	14	67	22.4
mother literate	45	41	42	47	175	58.3
Mother illiterate	30	34	33	28	125	41.7
Total:	75+	75+	75+	75+	300+	--
	75	75	75	75	300	--

The occupational status of the father and mother are as given in Table III. 72% of mothers, who are employed are eager to attend the PHC. 40% of the sample husband and wife are employed.



**TABLE III**  
**OCCUPATIONAL STATUS**

Employment	PHC		Field		Total	%
	ARI	ADD	ARI	ADD		
Father employed	40	46	75	75	236	78.6
Father not employed	35	29	-	-	64	21.4
Mother employed	54	66	25	21	166	55.3
Mother not employed	21	9	50	54	134	44.7
Both employed	36	36	24	24	120	40.0

Economic condition of the family influences the decision pattern.

The approximate percapita income of study group is Rs.118/- per month.

The family structure plays a vital role in the pattern of interaction in the process of decision making. Table IV.

**TABLE IV**  
**FAMILY STRUCTURE**

Family structure	PHC		Field		Total	%
	ARI	ADD	ARI	ADD		
Joint Family	18	26	21	26	91	30.3
Nuclear Family	57	49	54	49	209	69.7

## RESULTS

1. 71.6% of the women, including mother, female adult member, neighbouring women etc. decide on home remedy using either traditional way or allopathy irrespective of whether they use the PHC services or not. (Table V)



**TABLE V**  
**INFLUENCERS FOR HOME TREATMENT**

	self (by mothers)	other women	Husband	other	of self %
Utilizer of PHC Service	91	11	36	12	61%
Non utilizer of PHC service	110	3	7	30	73%
	201	14	43	42	-

women as decision maker  $(201+14) = 215$  (71.6%)

2. "self decision making" by mother to have home remedy is highly significant for those who do not avail the services of the PHC, than those who avail the services.

3. The influence of husband is 24% on the mother's decision process to attend the PHC. This is seen in all the nuclear family. This indicates husband is not passive in the event of illness in his family. He does not leave the decision making process exclusively to his wife to go to PHC. This is a healthy trend in the family's health in the changing sociey structure.

4. Administration of home remedy for both ARI and ADD is still only 54%. But among those not utilizing the PHC service and seeking to home remedy is 60.6% . In both cases 40.6% not having any remedy. This is very alarming as there is no early intervention for a simple perceivable ailment.



**TABLE VI**  
**SEEKING HOME TREATMENT**

	Both attended PHC and not for both ARI & Diarrhoea	%	Those attended PHC both ARI & Diarrhoea	%	Those not attended PHC	%
To have home remedy	163	54.3	72	48	91	60.6
Not having home remedy	137	45.6	78	52	59	39.3
Total	3000	-	150	-	150	-

5. In the experimental group of persons not availing health services the home remedy intake is more than those attending the PHC which is highly significant. (Table VI)

That may be the reason for not turning up to the PHC.

6. Average time taken to avail the PHC service also significant between the diseases ARI and diarrhoea. Table VII shows that for ARI the mothers wait for nearly 1.8 days more to avail PHC service. The respondent is quick in action for diarrhoea as she attribute diarrhoea very often to serious disease of cholera, but not so for ARI.

**T A B L E VII**  
**AVERAGE TIME TAKEN IN DAYS**

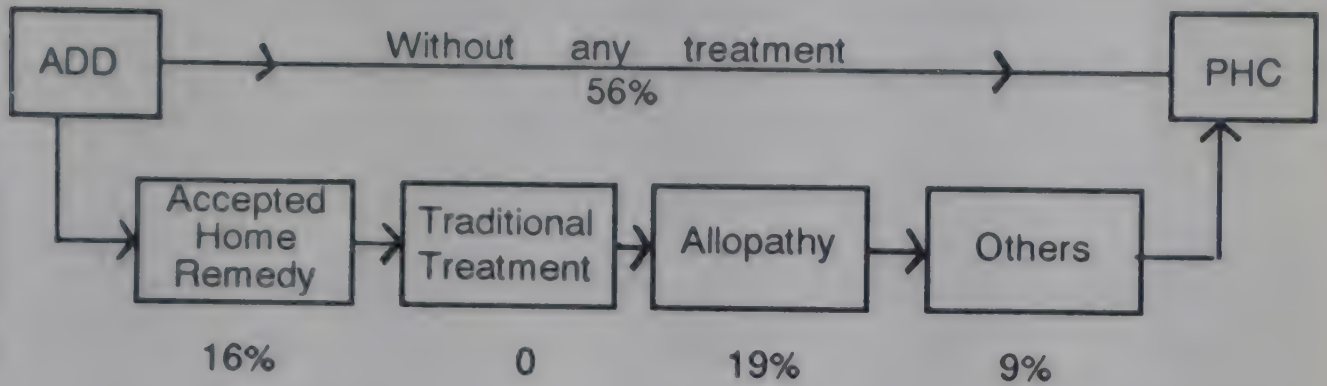
	ARI	Diarrhoea
To attend PHC	4.75	3.06

7. Without any home treatment 56% availed the PHC service for diarrhoeal diseases. Those who practice accepted home treatment for diarrhoea is only 16% and unacceptable unconventional country treatment is not practiced at all. Allopathy treatment of self medication of left-over medicines, prescription by village health nurse etc. is 19%. (Figure I)



FIGURE I

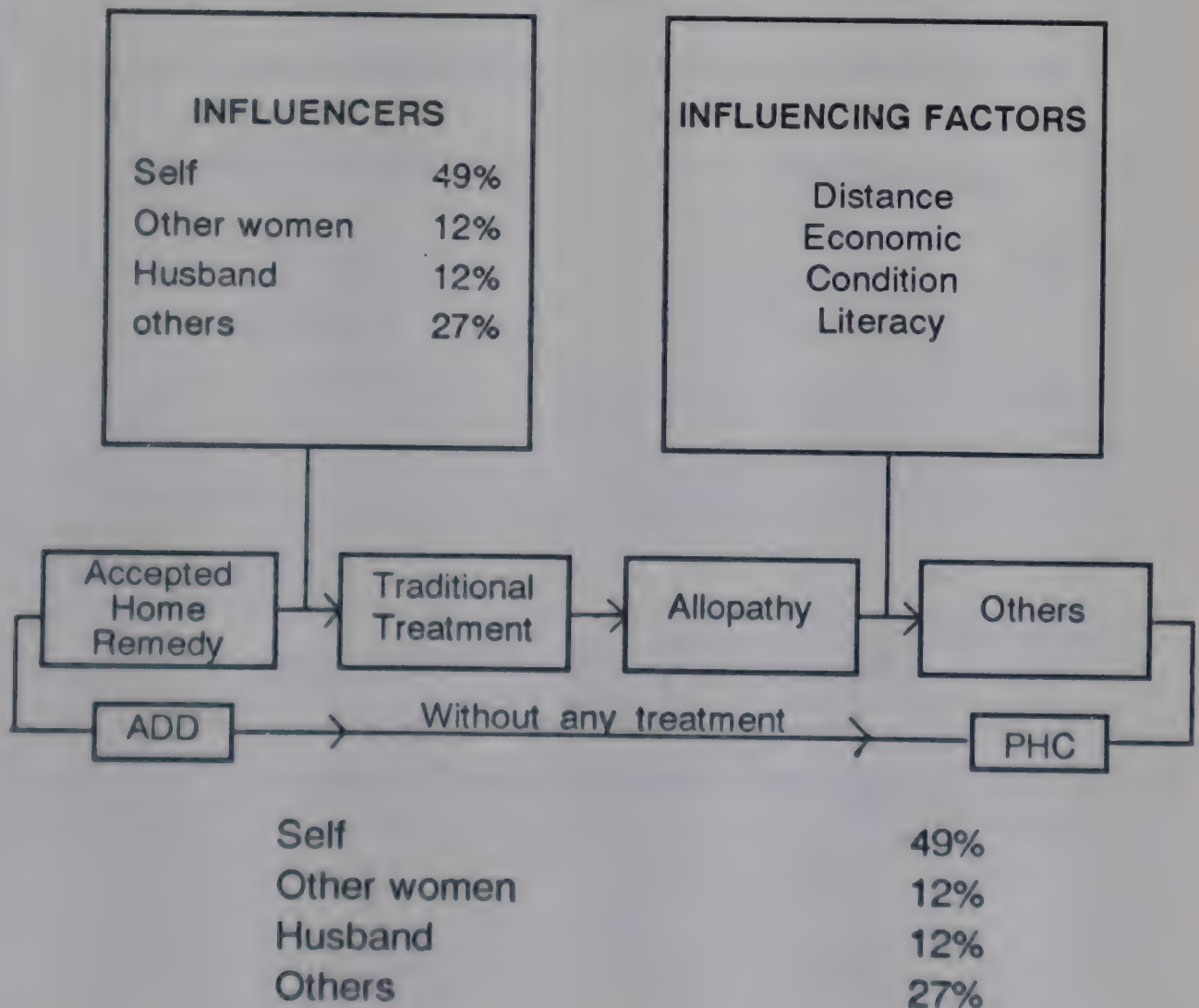
ADD - HOME CARE AND UTILISATION OF PHC FACILITIES



Those who influenced the intake of home treatment are significantly mother herself. (Figure II)

FIGURE II

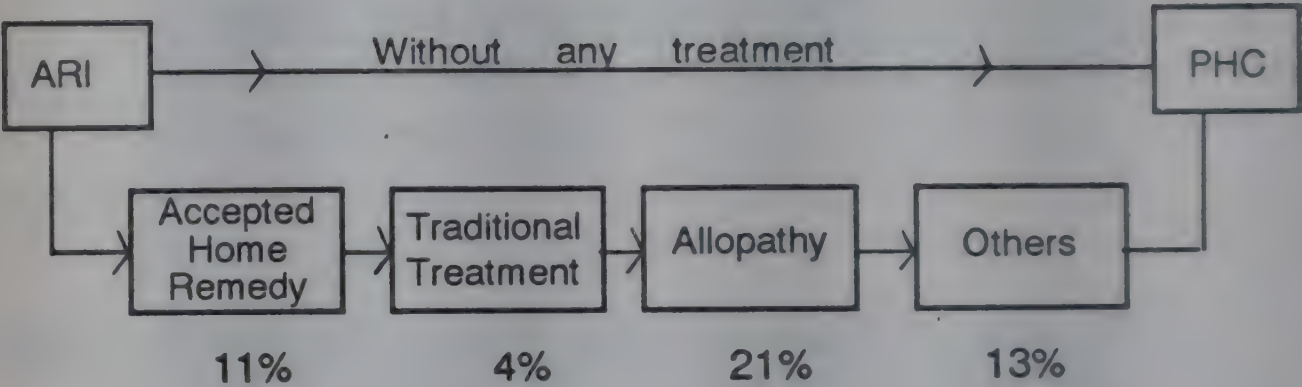
INFLUENCERS AND INFLUENCING FACTORS



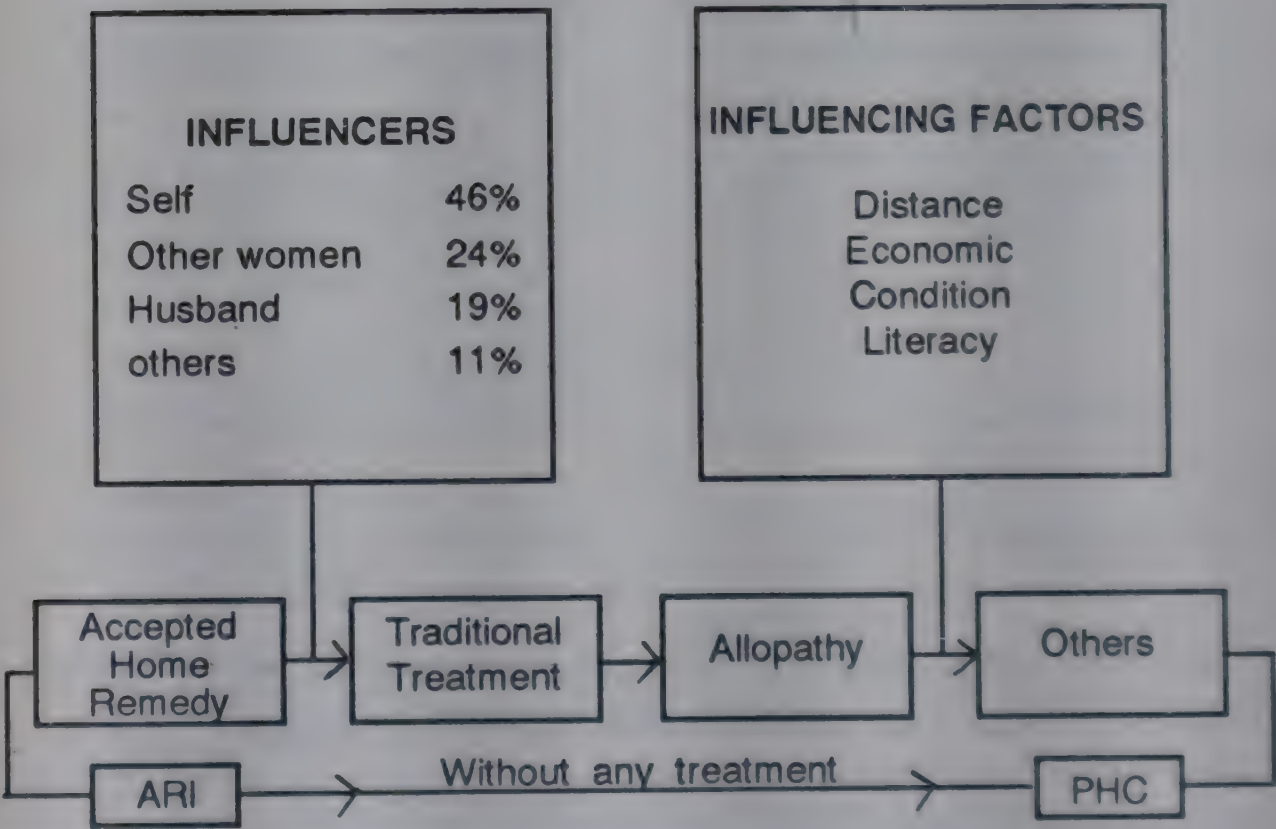


8. Similarly for Acute Respiratory infection 51% seek PHC service without having any kind of home treatment (Figure III) and the mothers play a major role 46% of in having home treatment (Figure IV)

**FIGURE III**  
**ARI - HOME CARE AND UTILISATION OF PHC FACILITIES.**



**FIGURE IV**  
**INFLUENCERS AND INFLUENCING FACTORS**





9. The awareness about giving more food during diarrhoea is very high 93.3% (72+68) but during ARI is lesser 79.3% (58+61). Table XI. There is no significant difference in the awareness of giving more food between utilizers and non utilizers of health services.

**T A B L E X I**  
**GIVING MORE FOOD**

	PHC		Field		Total	%
	ARI	ADD	ARI	ADD		
Aware	58	72	61	68	259	86.3
Not aware	17	3	14	7	41	13.7

The awareness by mother herself in giving more food is 66% and she is influenced to give more food by her mother and mother in-law etc. are 23%. Table XII.

**T A B L E X I I**  
**INFLUENCERS TO GIVE MORE FOOD**

Self decision	66%
Other women	23%
Husband	6%
Others	5%

10. The awareness to give more fluid during diarrhoea is 73.3 and during Acute Respiratory Infection is 53.3% which is below the expected level. There is very less difference to give more fluid among the user and non user during diarrhoea but not so during Acute Respiratory Infection.

**TABLE XIII**

	PHC		Field		Total	%
	ARI	ADD	ARI	ADD		
Awareness	41	50	39	60	190	63.3
Not aware	34	25	36	15	110	36.6



**T A B L E   X I V**  
**INFLUENCER TO GIVE MORE FLUID**

Mother	44%
Other women	27%
Husband	19 %
Others	10%

11.Awareness to give more food and fluid in case of ARI is less than the awareness to give more food and fluid in case of ADD. (Figure V and VI)

## **DISCUSSION**

The main aim of the child survival and safe motherhood (C.S.S.M.) programme is to equip the mothers to recognise at the earliest the conditions like Acute Respiratory Infection and Diarrhoea without dehydration and to have home care. Eventhough the mother herself decides on the home care, her recognition of illness is much delayed and nearly half of the conditions are without any kind of treatment.

The home available remedy and home available fluid (HAR-HAF) is yet to take root in the rural area eventhough decision making process appear satisfactory.

The attempt of making a "decisiogram" for an acute illness is unlike for a slow decision making process as in the case of decision on accepting family welfare or not (study by Dr.K.Mahadevan, Bulletin of GIRH Gandhigram Vol.III NO.1 July 1968)

The study revealed that there is considerable time lag in utilizing the health services even though the facilities are very near to them. It is noticed that delay is due to the awareness of home remedy in some cases but not so in all the cases.

Unipersonal decision by the mother is highly significant. There is postponement of decision by 1.8 days noticed in acute respiratory infection than the diarrhoea.

## **LIMITATION**

The attempt made at Madurai District is to study the decision process in a simple cheap and quick method. This may have the inherent demerits of a questionnaire type study. Similarly emotional difference and depth of respondent in acute illness is not taken into consideration.



## SUGGESTION

The influencer within the family are gradually narrowing down in our changing society, from a joint family system to a nuclear family system. Further the small family norm makes the mother more anxious about her child. In this social changes, the mother and father must both bear a collective responsibility in making a decision rather to depend on in-laws. The influencing factors also vary over space and time and is easy to tackle with process of education.

The present health education process must have a thrust, especially in the area of ARI control programme. Hence health care planning requires changing trends of health education for the betterment of children and women.



# COMMUNITY INVOLVEMENT IN HEALTH SUB CENTRE CONSTRUCTION.

## AN EXPERIENCE

## AN EXPERIMENT BY TAMIL NADU DANIDA HEALTH CARE PROJECT

*Dr. G. Vittalraj, BSc, MBBS, BSSc.,*

## INTRODUCTION

World Health Organisation defines Community Involvement in Health and Development as follows: is a process by which partnership is established between the Government and the local communities in planning, implementation and utilisation of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of Primary Health Care.

DANIDA: Danish International Development Assistance is an external aided area project implemented in two Districts of Tamil Nadu i.e., Salem and South Arcot, with a noble aim of improving the health status of the rural population particularly women and children, in accordance with the Global Strategy of 'Health for All by 2000 A.D.

The Project started functioning from 1981 onwards and still continues. The project components include apart from other things, the following.

- Health sub centre construction.
- Logistic support at Health Sub Centre, Primary Health Centre and Community Health Centre level.
- Training and I.E.C activities and
- Drug supply and management
- Health Information system.

## HEALTH SUB CENTRE CONSTRUCTION BY THE COMMUNITY

Health sub centre is the prime unit of the Health care Delivery System. Hence the Project activities are focused to strengthen the infrastructural facilities at Health Sub Centre level., by replacing all the rented buildings of the Health Sub Centres with own Government buildings.

---

*Dr. G. Vittalraj, Bsc., MBBS, ESSc.*

*Principal, Health and Family Welfare Training Centre, Egmore, Madras-8*



The main reason for this view is that rendering the effective MCH and the related health care services from the rented buildings posed problems of inadequate space, Restrictions imposed by the house owners, communal problems and water problems.

During the first Phase of the Project, Health sub centre building construction was executed through Government Departments like Public Works Department or Panchayat Development authorities. 238 Health sub centre buildings were constructed by the above said agencies. The total cost of such buildings was borne by the project.

## **GENESIS OF THE CONCEPT**

The Public of the two villages namely Parapatti and Kammalapatti where Health sub centres are functioning in rented buildings, approached the District Project organisation and demanded Health sub centre buildings for their villages. Their offer was considered positively with the suggestion that certain amount will be given by Danida and the community has to contribute resources and complete the Health Sub Centre construction by the community itself without engaging any contractors or Government agencies. The suggestion was accepted by the Community. Rs 50000/- had been sanctioned to each Health sub centre building as Danida Grant. Village Health councils were established in the two villages. The village Health council shouldered their responsibility of executing construction work. VHC planned the strategy for construction work. A design of the building was developed to match the other buildings in the village. Two Health sub Centre buildings were constructed, which cost about Rs 90,000/- each. The success of this process made the project to try this experiment, on a larger scale, to study the feasibility to expand in other places.

## **IDEALISM BECAME REALISM**

During the 2nd phase of the project, there were 178 Health sub centres functioning in rented buildings. The project has committed to replace all the 178 buildings with Danida supported community constructed Health sub centre buildings.

Since, this is an innovative community based developmental scheme, the scheme was implemented in a phased manner instead of constructing all the Health sub centre buildings at a stretch. Accordingly Government sanction was accorded as follows:

1989-90	10 Buildings.
1990-91	70 Buildings.
1991-92	70 Buildings.
1992-93	28 Buildings.



Danida contribution of Rs. 90,000/- (Rs. Ninety thousand only) have been sanctioned to each building.

## **VILLAGE HEALTH COUNCILS**

Village Health councils were established in all the places where sanction have been accorded for Health sub centre construction. Local Influential leaders, youth representatives, teachers, community leaders and other representatives of the community form part of the Chairman and Members of the council. The Village Health Nurse and the Multipurpose Health Assistant who are the Health functionaries at Health sub centre level are the two member secretaries. Village Health councils are made responsible to execute the construction work.

## **GOVERNMENT GRANT AND COMMUNITY RESOURCE MATCH EACH OTHER**

Government contribution of Rs.90,000/- is deposited in the joint account of the concerned Primary Health Centre Medical officer and the chairman of the village Health council in a nationalised or co-operative Bank. According to the need not exceeding Rs. 10,000/- at a time will be fetched from the bank for every 10,000/- drawn from the Govt. fund, community has to contribute Rs.5,000/- approximately. Community contribution is collected in terms of money, material and labour. Mobilising the local resources is the responsibility of the village Health council.

## **ROLE OF PRIMARY HEALTH CENTRE**

Primary health centre medical officer and concerned field staff act as a team. The primary health centre team coordinates with the VHC, motivates the community to involve voluntarily in the process of construction of health sub centre building, assists in mobilising the resources, laise between the project organisation and the VHC, monitor the progress of construction, and reports to the higher ups.

## **DISTRICT PROJECT ORGANISATION**

Initiates the action, proposes for sanction of the scheme, streamline the entire construction process, monitor the construction progress provides the technical support and plays the role of problem solving, wherever and whenever there is problem, either between the community members or between the community and the Primary Health Centre team. Under the direction of the District project officer, District Project organisation co ordinates with other departments like Revenue, Banking, Health and Medical, and the Rural Development.



## **ACHIEVEMENTS**

Out of 178 Health Sub Centre buildings sanctioned so far, 90 buildings were completed structurally in all respects, out of which 50 buildings are put into use. Remaining buildings are under various stages of construction, and in progress.

Out of Rs.90,000/- investment, in the business of community construction benefit for the Government, in terms of community contribution varies from Rs.20000/-to Rs 100000 to each building excluding the land cost. It is worth to mention here that in more than 25% of the places, the land for Health sub centre construction was donated by the Public. In some places the value of the donated land exceeds one lakh rupees.

## **COMMUNITY BORE WELLS**

It is the commitment of the project to provide water supply to all the Health sub centres, functioning in the Project District, either through Bore wells or through extension of pipelines from the Public overhead tank. Likewise, initially borewells and electric motor were executed through the various Government Departments. Bore wells are provided not only for the use of the Health sub centre but also for the utilisation of the community. At present, providing bore wells also, community involvement is sought and the village Health council is made responsible to execute the Bore well work, for the community constructed Health sub centres. Hence it is an another milestone, in bringing community involvement in Health care activities. For providing water supply, the entire amount is given by the Government.

## **RISK FACTORS**

1. Non availability of Government Poramboke land for construction in the midst of habitation, which is accesable and acceptable to the community in all the places.
2. This is the key factor which ensures the resident village Health Nurse, to deliver the services round the clock.
2. Bottle Neck in acquisition of land :
  - a. Delay in getting permission for some categories of Govt. owned lands.
  - b. Unauthorised land holding rights by the Private persons.



- c. High cost of land made unaffordable by the community to purchase for construction.
- d. High land levelling cost.
3. Non availability of perennial water sources, which blocks the bonus to the community.
4. Identification of dedicated and influential village Health council chairman.
5. Poor back ground of the community and lack of resources which causes much difficulty in mobilising community contribution.
6. Difference of opinion between the community members.
  - a. Political problems.
  - b. Communal problems.
  - c. Class differences.

## **PLUS POINTS**

- Lowering the over all cost of the HSc building.
- Cost effective and qualitative construction.
- Encourage the facility of ownership which have direct bearing on the better utilisation of the services.
- Community understands the services provided at the Health sub centre.
- Demands and ensures the village Health Nurses stay in the quarters.
- Accountability' of the Health functionaries to provide better services.
- Community participation in construction facilitated for community participation in the delivery of services

## **CONCLUSION**

Community is in the trial and error stage to act as a co-partner in the Health services delivery, and in healthful living community participation is possible in health care activities. Danida Health care project had a success story in the community supported Health sub centre construction. Community constructed buildings do not stand there as a mere structure of brick and cement mortar, unloaded on the community by the external system but are carefully created monuments by the people, for the people.



# ASSESSMENTS OF THE IMPACT OF NUTRITION/HEALTH EDUCATION ON MOTHERS OF SCHOOL CHILDREN

*D.Malathi Ravindran and Dr.Usha Chandrasekar,*

## INTRODUCTION

Nutrition education is defined as a process of applying a knowledge of nutrition related scientific information, social and behavioural sciences in ways designed to influence individuals and groups to eat the kinds and amounts of foods that will make maximum contributions of health and social satisfaction (Obert, 1978). Nutrition education should be practical and adopted to suit the socioeconomic conditions, food habits and local food resources. It should include effective demonstration feeding in which mothers take active part (Swaminathan, 1985).

Demonstration is a good method to teach certain skills because demonstrations combine seeing with learning and also points out that it should take place where a group can gather to see and hear the information (Alamelu, 1988)

Though nutrition education is important, nutrition evaluation is equally important to study the impact of nutrition education. Thus the evaluation confirms the degree of success or failure.

The basic objective of this study was to see nutritional knowledge/attitude/practice of the mothers of the children attending the selected noon meal programme and children's knowledge regarding nutrition health and environmental sanitation were also evaluated before and after the nutrition programme.

## MATERIAL AND METHODS

The 125 mothers of the children in the noon meal programme were enlightened about the importance of good nutrition, need for adequate diet for all age groups, extra nutritional care during pregnancy, lactation and weaning stages and the important role of environmental

---

*D.Malathi Ravindran*

*Tamil Nadu Agricultural University,  
Coimbatore.*

*Dr. Usha Chandrasekar*

*Sri Avinashilingam Deemed University, Coimbatore.*



sanitation, Immunization and hygiene. A special proforma was administered to assess the intitial nutritional knowledge of the mothers and the same proforma was used after the completion of the nutrition education sessions to study the impact of nutrition education of their knowledge.

Nutritional awareness of the mothers before and after participation in the nutrition education session were also elicited through personal interview. Improvmnts in the food consumption pattern of families of the mothers who participated in the nutrition programme was assessed.

The main objectives of nutrition education to children was to make them aware of importance of nutritious food especially protein rich defatted soya flour in their daily diet and the need for following basic principles of health and hygiene in daily life. All the children in the experimental group were exposed to Nutrition/Health education programme by the investigator. The nutritional knowledge of the children was assessed using the scoring technique.

**RESULTS AND DISCUSSION**

Nutrition education was given to assess the nutritional knowl- edge/attitude/practice of the mothers of the children attending the selected noon meal programme and also for the children’s knowledge regarding nutrition, health and environmental sanitation. The results obtained are discussed below:

In order to assess the overall nutritional knowledge of the mothers the same questions regarding nutrition were asked in the beginning and at the end of the nutrition education sessions. The scores obtained by the mothers in the beginning and at the end of nutrition education sessions are given in Table I.

**TABLE I**

**PERCENTAGE SCORES OBTAINED BY THE MOTHERS BEFORE AND AFTER NUTRITION EDUCATION**

Intial score	Final score	Difference
2.5 • 4.17	63.0 • 10.36	60.5 • 12.14



After participating in the nutrition education session, the nutritional knowledge of the mothers were improved. The retention was around 60 per cent and it indicated the possibility of improving the nutritional knowledge for the mothers in the rural areas.

Nutritional awareness of the mothers who participated in the nutrition education programme is given in the Table II.

**TABLE II**  
**CHANGES IN NUTRITIONAL AWARENESS OF THE MOTHERS**  
**BEFORE AND AFTER NUTRITION EDUCATION**

Concepts	Percentage	
	Before	After
Adequate diet is important for all the age groups.	20	90
Extra nutrients are needed during pregnancy and lactation	10	90
Proper introduction of weaning foods is essential	25	85
Immunization is necessary	10	80
Personal hygiene is important	10	90

Before participating in the nutrition education classes only 20 percent of the mothers were aware of the importance of adequate diets for all the age groups. But after nutrition 90 percent of the mothers came to understand the importance of adequate diets for all the age groups. Only one percent of the mothers were aware of the extra nutritional need during pregnancy and lactation. After nutrition education 90 percent of the mothers realized the need for extra nutritional care during pregnancy and lactation. In the same way only 25 percent of the mothers were aware of the importance of introduction of weaning foods before nutrition education and after nutrition education 85 percent of the mothers were convinced about the proper introduction of weaning foods. The same trend was observed regarding the awareness of immunization and personal hygiene.

Table III presents changes in the practices of the cooking methods before and after nutrition education.



**TABLE III**  
**CHANGES IN PRACTICES OF THE COOKING METHODS**

Practices	Number mentioned	
	Before	After
Cutting of the vegetables into big pieces	5	125
Cooking rice by the absorption method	10	125
Cooking vegetables with enough water	15	125
Avoiding soda	15	125
Sprouting of pulses	15	125
Inclusion of defatted soya flour in their dietaries	2	125

Before nutrition education only 5 mothers were used to cut vegetables into big pieces, but after nutrition education, all the 125 mothers started cutting the vegetables into big pieces. Absorption method of cooking rice was practiced by only 10 mothers before nutrition education.

But after nutrition education all the 125 mothers started practicing the absorption method for cooking rice. Only 15 mothers were under the practice of cooking vegetables with enough water. But after nutrition education all the 125 mothers started using enough water for cooking vegetables. The same trend was observed regarding the practice of avoiding soda and sprouting pulses. Before nutrition education only 2 mothers were willing to introduce defatted soya flour in the daily dietaries. But after participating in the nutrition education all the 125 mothers were willing to introduce defatted soya flour in the daily dietaries.

The scores obtained by the children for the knowledge regarding nutrition, health and environmental sanitation assessed using the scoring procedure with specially designed proforma is given in Table V.



**TABLE IV**

**PERCENTAGE SCORES OBTAINED BY THE CHILDREN  
BEFORE AND AFTER NUTRITION EDUCATION**

Scores obtained Before Nutrition education	After Nutrition education
12.5 • 10.10	70.5 • 3.50

The knowledge regarding nutrition, health and environmental sanitation of the children was improved by 58 per cent after they participated in the nutrition education sessions.

**CONCLUSION**

Through nutrition education the mothers nutritional knowledge/ attitude/practices and the knowledge regarding nutrition, health and environmental sanitation of the experimental group were improved. Nutrition education can go a long way to improve the knowledge, attitude and practices of the people. Thus the study paves the way for exploring the possibility of introducing low cost locally available new entrants of agricultural production into the common dietaries to fill the nutrient gaps and to help to achieve self sufficiency.

**REFERENCES**

OBERT, J.C. 1978, Community Nutrition, John Wiley and Sons, New York, P-73-242.

SWAMINATHAN, M, 1985 "Assessment of Nutritional status" Essentials of food and Nutrition Vol.II publishing company, Bangalore P411-441.

ALAMELU, S. 1988. Problems of Tribal education social welfare, vol XXXVIII, No. 5, P14-15. 70.5+ 3.50



# IMPACT OF NUTRITION/HEALTH EDUCATION ON FARM WOMEN

*M. Aruna Seralathan and S. Neelakantan*

## INTRODUCTION

Women in India, since time immemorial have formed an organic component of the working force in the country (Singh, 1989). The census data reveals that in the total rural population, 48 percent belong to female population. Women are usually being inexorably elbowed out of all remunerative well paid work. Kaur (1989) has reported that over the centuries millions of women in the rural regions of India have been carrying on their shoulders the burden of poverty, ignorance, superstition, and out-moded customs and traditions. He has also reported that one can call her the unsung heroine of our country, who without any glare of publicity, contributes her best to the welfare and progress of our country.

Unlike western countries, women in India are mainly unemployed house makers. These employed women in rural areas constitute 19 percent of the total rural work force (UNICEF, 1985). Women in India have generally a lower status than men in the society. The existing socio - economic cultural frame work lower the position of women in society. In India like in any other backward, post-colonial country, women workers are treated as cheap labour. (Panduranga Reddy, 1990).

Education is an important factor, influencing economic status of women. In India, the literacy rates for females is only 24.82 percent (Gopalan, 1987). Rate of literacy among rural women is only 13.2 per cent as against 42.31 percent in the urban sector. (UNICEF, 1985). According to Rajagopalan, (1986) the female literacy level is on the rise in Tamil Nadu over the decades, though it is still low at 35.0 per cent compared to the male literacy level of 58.5 per cent. Higher school drop out rate for girls in Tamil Nadu is because they are increasingly drawn out of the school system to undertake domestic work.

Gulati (1984) has reported that almost 50 per cent of rural female workers are sole supporters of their families. Large majority of rural women are reported to prefer to remain in villages seeking occasional

---

*M. Aruna Seralathan and S. Neelakantan*

*Food Science and Nutrition Unit, Tamil Nadu Agricultural University,  
Coimbatore*



employment available within short distance. According to Gowda and Indira (1987) as many as 75 per cent of the women workers in India are the sole wage earners in their families. Gulati (1984) has found that daily nutritional adequacy in agricultural labour households in Kerala was related to women's employment than to men's employment. A case study conducted in India among employed women has found that increasing women's wages has a visible effect on child nutrition (Chakrabarthy, 1985).

Bagchi and Umesh (1985) have reported that income generation of rural women is regarded as an important measure in the amelioration of rural poverty and that increased income at the family level leads to increase caloric intake of infants and pre-schoolers.

As wives, daughters or mothers of the male who are hired, women in traditional systems of employment are often required to work without any payment at all or at best for payment of a small pittance (Chitnis, 1983). He has also reported that the female labour force, particularly the female labour force employed in agriculture and in other unorganized sectors of the economy, is highly disadvantaged in terms of self protection and bargaining power and is therefore highly subject to exploitation. The agricultural system is heavily dependent on female labour and characteristically women perform some of the most strenuous yet vital tasks such as weeding and transplanting. More than 50 per cent of the agricultural operations are done by farm women.

Even though women contribute a lot to the welfare of the family, discrimination is shown in allocation of facilities at the house hold level. Dandekar (1975) has stated that a greater proportion of ailing women than men received no treatment and those women who were treated received mostly house remedies, or traditional medical care while men received institution based care. Jain (1980) has reported the discrimination in the allocation of food between males and females within the family, with males getting the better food. According to Ghosh (1989) discrimination in feeding and allotment of work at the domestic sector make most rural women physically weak, undernourished and malnourished. Women who are employed undertake an extremely strenuous load of work in addition to the work load at home. According to Srivastava (1985) the continuous fatigue due to the dual role does not allow her recoup the defence mechanism. Maternal morbidity, frequent births, heavy household work and lack of opportunities contribute to the low health profile of women and girls in the 40 to 50 per cent of the population below the poverty line (Rajagopalan, 1986). Anemia, gastro



intestinal ailments, respiratory diseases, malnutrition, tuberculosis, parasitic infestation and malaria are reported to be common nutrition and health disorders prevalent among women in our country (Kishwar, 1988). Bagchi and Umesh (1985) have reported that strenuous work load both outside and inside their home puts a great strain on malnourished women during their pregnancy period.

## MATERIALS AND METHODS

This study was conducted at the orchard of the Horticulture College and Research Institute of Tamil Nadu Agricultural University. One hundred and fifty women were surveyed to elicit information on their socio economic status, nutritional status and nutritional knowledge. Later Nutrition education was given through charts, lecturers demonstration and the impact of the education was determined through nutrition knowledge, attitude/practice tests before and after the education programme.

## RESULTS AND DISCUSSION

The findings of this study were as follows:

The socio economic status of farm women as revealed by the socio economic scores is given in Table I:

**TABLE - I**  
**DISTRIBUTION OF FARM HOUSE HOLD AS PER THEIR**  
**SOCIO - ECONOMIC STATUS SCORES**

Sl. No.	Socio Economic Status		(Farm House Holds)	
			Daily wages.	Monthly wages
1.	LSS- Low Socio economic status	63(42)	63(42)	-
2.	LMSS - Lower middle socio economic status	87(58)	45(30)	42(28)
3.	MSS - Middle socio economic status	-	-	-
4.	UMSS - Upper middle socio economic	-	-	-
Total		150(100)	108(72)	42(28)

Figure in parenthesis represent Percentage



From Table - I it is evident that all farm women on monthly salary were able to maintain better socio -economic status (LMSS) than women on daily wages. However , 30% of women on daily wages fall in the LMSS category which can be attributed to higher total income earned by other members of the family, lesser numbers of children and dependents and own houses. The figures show that 42% were categorised as LSS while the remaining 58% as LMSS. None of the farm household reached the status of MSS or UMSS.

The adequacy of dietary intake was studied in terms of foods and nutrients. The daily intake of food items by farm women is given Table II.

**TABLE - II**  
**DAILY MEAN INTAKE OF FOOD ITEMS BY FARM WOMEN.**

No Foods	RDA	Monthly Salary group Mean % excess or deficit	Daily wages group Mean % excess or deficit	All farm women Mean % excess or deficit
1. Cereals(g)	350	382.5 +9.29	371.81 +6.23	374.8 +7.09
2. Pulses (g)	55	30.71 -44.16	26.39 -52.02	27.6 -49.82
3. Green leafy Vegetables(g)	125	7.5 -94	2.92 -97.67	4.2 -96.64
4. Other Vegetables(g)	75	34.64 -53.81	14.44 -80.74	20.1 -73.2
5. Roots and tubers (g)	75	11.07 -85.24	3.89 -94.82	5.90 -92.13
6. Fruits (g)	30	15.71 -47.62	1.67 -94.4	5.06 -81.33
7. Milk (g)	100	107.1 +7.1	64.17 -35.83	76.2 -23.8
8. Fats and oils (g)	40	0.71 -72.73	5.78 -85.55	7.16 -82.1
9. Sugar and Jaggery (g)	30	12.14 -59.53	9.03 -69.9	9.9 -67.0
10 Meat and fish (g)	30	11.64 -61.2	5.28 -82.4	7.06 -76.47
11. Eggs (g)	30	3.57 -88.1	2.08 -93.07	2.5 -91.67



The intake of almost all the food items except cereals were found to be on the deficit side. Very high range of deficit was noticed in the case of green leafy vegetable, other vegetable, roots and tubers, fruits, fats and oils, meat, fish and eggs.

The deficit in food intake was found to be lower in the diets of farm women on monthly salary. The intake of all food items showed a very high deficit range in the diets of women on daily wages. However the cereal consumption was excess in the range of +7.09% in the diets of the 50 farm women surveyed. Thus cereals namely rice was the staple food and formed the basic and bulk component of the diet. Pules, vegetables, fruits, milk and milk products etc. were included as and when available. The nutrients supplied by the daily food intake of farm women is given in Table III.

**TABLE - III**  
**DAILY MEAN INTAKE OF NUTRIENTS BY FARM WOMEN**

No Nutrients	RDA (ICMR)	Monthly salary Mean% excess or or deficit		Daily wages Mean % excess or deficit		All farm women Mean% excess or deficit	
1. Proteins (g)	50	37.48	-25.04	33.41	-33.18	34.55	30.9
2. Fats (g)	20	11.62	-41.90	11.37	-43.15	11.44	-42.8
3. Carbo- hydrates (g)	425	335.94	-20.96	327.145	-23.02	329.61	-22.44
4. Energy(Kcal)	2225	1674.0	-24.76	1491.7	-32.96	1542.8	-30.66
5. Calcium (mg)	400	141.61	-64.60	137.5	-65.63	138.7	-65.33
6. Iron (mg)	30	23.81	-20.63	21.026	-29.91	21.81	-27.3
7. Carotene (ug)	2400	370.61	-84.56	348.74	-85.47	354.87	-85.21
8. Thiamine (mg)	1.1	1.07	-2.73	1.05	-4.55	1.06	-3.64
9. Riboflavin(mg)	1.3	0.496	-61.85	0.387	-70.23	0.417	-67.92
10 Niacin (mg)	14.0	10.10	-27.86	10.53	-24.79	19.69	-23.64
11. Vitamin C(mg)	40	19.73	-50.68	16.092	-59.77	17.111	-57.22

The comparison of the average nutrient intake with the RDA of ICMR (1989) shows a gross deficit with respect to all nutrients. The deficit was higher in case of fats (-42.8%), calcium (65.33%) Carotene (-85.21%) Riboflavin (-67.92%) and Vitamin C (57.22%). The deficit



percentage was higher in the diets of farms women on daily wages than in the case of farm women on monthly salary. Thus from the above two tables it may be concluded clearly that income has a definite bearing on the food and nutrient intake.

The body mass index (B.M.I.) of the farm women was calculated and classified into the grades of chronic energy deficiency (CED). The results are given in the table below:

**TABLE - IV**  
**BMI OF FARM WOMEN LABOURERS.**

Number	BMI Classification	percentage of farm women	Average height cm	Average weight kg	Average BMI
1.	CED grade III	8	153.25	35.75	15.21
2.	CED grade II (moderate)	6	149.66	37.33	16.67
3.	CED grade I (Mild)	32	149.75	39.50	17.63
4.	Low weight normal	22	144.91	40.00	19.05
5.	Normal	32	135.13	45.44	24.83
6.	Obese Grade I	-	-	-	-
7.	Obese Grade II	-	-	-	-

From the above Table IV it is evident that 46% of the farm women are suffering from different grades of chronic energy deficiency. The average height of the farm woman was 135.13 cm while the average weight was 45.44 kg. Twenty two per cent of the farm women had an average body mass index of 19.05. They were classified under the low weight normal group. Eight per cent of the farm women were suffering from grade III, severe chronic energy deficiency which was a clear indication of very poor nutrition status.

Nutrition education was given to assess the nutritional knowledge/attitude/ practice of the farm women. About 150 farm women were given nutrition education through charts, lectures, demonstration and the impact of the education was determined through questionnaires on a 5 point scale. Results obtained are given in Table V.



**TABLE V**  
**MEAN SCORE OF NUTRITIONAL KNOWLEDGE**

No.	Subject Matter	Before	After
1.	Knowledge regarding nutrients	1.75	3.93
2.	Knowledge regarding cooking method	1.46	3.51
3.	Knowledge regarding personal hygiene	1.46	3.39
4.	Knowledge regarding environmental sanitation	1.65	3.74
5.	Knowledge regarding breast feeding	1.54	3.54

The above Table depicts the knowledge aspects regarding:-

1. Nutrients like Vitamin A - rich food, iron rich food, Protein and fat rich food were evaluated and was found that the mean score before education was 1.75 which rose up to 3.93 after education.

2. Cooking methods adopted like draining off the cooking water, cutting vegetables etc. showed a mean score of 1.46 before education and 3.51 after education.

3. Personal and environmental sanitation dealt with bathing practices, washing of hands, maintaining environmental cleanliness ranged from 1.46 to 1.65 before, which increased after nutrition education to 3.39 to 3.74 in their mean scores.

4. Breast feeding practices like colostrum and its importance, weaning and supplementary practices showed a mean score of 1.54 initially which increased to 3.54 after education.

Thus through nutrition education, the nutritional knowledge of farm women was found to improve.

## **2. NUTRITIONAL ATTITUDE**

The 150 farm women who attended the education programme were evaluated for their attitudinal changes. The results obtained are discussed below. Five point attitude scale was adopted (i.e. 5 strongly agreeable, 4 -agreeable, 3 - no-idea, 2-disagreeable, 1-highly disagreeable).



**TABLE VI**  
**NUTRITIONAL ATTITUDE BEFORE AND AFTER NUTRITION**  
**EDUCATION**

No.	Attitudes	Before					After				
		5	4	3	2	1	5	4	3	2	1
1.	Breast feeding	30	52	5.3	8	4.8	45.3	52.8	-	2	-
2.	Introduction of weaning foods	2	4.76	42.7	32.7	18	7.3	31.3	26	22.7	12.7
3.	Incorporation of Green leafy vegetables to prevent anaemia	18	38.7	20	18.7	4.7	36	53.3	10.7	5.3	1.3
4.	Nutrition adequacy during pregnancy	26	62.7	11.3	-	-	28.7	71.3	-	-	-
5.	Importance of prevention anaemia	2	76.7	5.3	12	4	6.7	83.3	-	8.7	1.3
6	Immunization	27.3	62	10.7	-	-	30.7	69.3	-	-	-

There was a considerable increase in attitudinal changes in the strongly agreeable and the agreeable group. A decrease in 'no idea', disagreeable and highly disagreeable group were noted.

### 3. NUTRITIONAL PRACTICES

The nutrition education was very much useful to the farm women as it helped them to improve the present practices like cooking methods, preservation, weaning and supplementary practices, sanitation, diet during illness and special conditions. The results obtained are given in Table VII.



TABLE VII

## NUTRITIONAL PRACTICES BEFORE AND AFTER NUTRITION EDUCATION

No. Nutritional practices	Before		After	
	No	%	No	%
1. Using the absorption method of cooking rice	56	37.3	120	80
2. Washing vegetables before cutting	53	35.3	96	64
3. Preserving foods (pickling, vadam etc)	46	30.7	83	55.3
4. Keeping the environment clean	76	50.7	126	84
5. Utilising kanji or strained water to cook other foods	15	10	71	47.3
6. Following ORT method	21	14	83	55.3
7. Boiling water before drinking	17	11.3	78	52

The practices after education improved in all the cases that were evaluated.

Hence it is very clear that nutrition education enables the rural and urban community to adopt desirable nutrition and health practices.

## REFERENCES

- Singh B. N. 1989, "Women work force, problems and prospects" *Yojana* 33 (4) : 15-17
- Kishwar, 1988, "The burning falls of our share," *Manushi*, 47:29-31.
- Kaur, 1989, *Rural Women*, Kuruskshetra, 37 (10): 3-5
- Bagchi K. and Umesh K 1985. "Effect of income generation of rural women on health and nutritional status of their offspring," *Swasth Hind* 29(20): 53-54.
- Chitnis S, 1983, *Women and Development not by constitutional gurantees or legal provisions alone*. *The Ind.J. of Social Week*, XLIII (4) : 401-417.



- Sreenivas, 1930, 'The invisible women', Yojana 21(13):13-14.
- Sharma, K, 1985, "Women and Development, gender concerns," Centre for Development studies, Occasional paper No.2.
- Dandekar K, 1974, 'Has the prospect of women in India's population been declining," Economic and political weekly, 10:13-19.
- Jain D 1980, Poverty and unemployment, Yojana, 24(16):6-7
- Ghosh D.K. 1989, IRDP and rural women as assessment, Kurukshetra 37(10): 32-33.
- Srivastava J.C. 1985, "Application of Science and Technology to eliminate drudgery among rural women' -paper presented in the seminar on appropriate technology for rural women in NTRD, Hyderabad, 3-5.
- UNICEF, 1985, "The state of the World's women," Swasth Hind, XXIX (12): 194-293.
- PandurangaReddy, 1990, 'Construction workers' Yojana 34(22):28-29
- Gopalan,S. 1987 'Why are women lagging behind?' Kurukshetra, 36(3):30-31.
- Rajagopalan, 1986, 'Women In Tamil Nadu - A Profile'. The Tamil Nadu Corporation for development of Women, Madras 1-12.
- Gowda S and Indra R 1987, "Women workers in Agarbathi Industry - A study," The Cud.J. of Social work, XLVIII(3):248-255.
- Chakrabarthy S 1985, "Rural Women's claim to priority, A policy debate selected documentry from International and Indian Archives", Centre for Development studies, 5-8.



# HEALTH EDUCATION AND COMMUNITY PARTICIPATION

## D.E.C. MEDICATED SALT PROJECT IN RURAL FILARIASIS CONTROL

*Dr. T. Jayakumar. M.B.B.S: P.G.D.Pr.M:(D.P.H.)*

### INTRODUCTION

Lymphatic filariasis due to *Wuchereria bancrofti*, has been a major public health problem in urban areas of the districts of chengalpattu M.G.R., 'North Arcot Ambedkar, Thiruvannamalai Sambuvarayar, Villupuram Ramasamy Padiyachi, South Arcot Vallalar, Nagapattinam Queid-E-Milleth, Thanjavoor, Tiruchirapalli and Kanyakumari, in Tamil Nadu. Control of Bancroftian filariasis has been carried out through the filaria control units and night clinics under National Filaria Control Programme. The strategy consists of detection and treatment of microfilaria carriers with Di-ethyl carbamazine citrate (D.E.C) tablets and weekly larviciding with other anti - larval measures and minor engineering methods to control the density of mosquito vector namely *Culex quinquefasciatus*.

During the past one decade or more trend of this disease spreading to rural areas of this state, as a result of intense movement of population between urban and rural areas has been noticed and because of increase in water supply in rural areas, without simultaneous scheme for disposal of sullage waters, which created high vector potential in these areas.

At present, there was no provision under National Filaria Control Programme, for control of Bancroftian filariasis in rural areas, since the strategy of urban filaria control is not practicable in rural areas. Thus, there was a felt-need, for an alternate strategy, for rural filariasis control.

With this object in view, as already conducted trials with 0.2 per cent D.E.C. mixed with common salt and distributed for ingestion by the community in Orissa, Lakshadweep and Karaikal near Pondicherry, was found effective in reducing the mortality rate and acceptable by people for use, we launched D.E.C. medicated salt project, for the first time, in Tamil Nadu, in a remote village Kiliyur of Ulundurpet Taluk with two



other villages Pallavadi and Periyakurukkai in the same area as control. We selected these villages because, the filaria endemicity was very high, about 18-20 per-cent in all the three villages and also there was a strong felt-need by the village people. The field trial was conducted for a period of two years and the results were evaluated.

The results showed that, all the important parameters like, microfilaria rate, average microfilaria count, and disease manifestations in the host have remarkably come down, with simultaneous reduction of microfilaria rate, infection rate and infectivity rate in vector to almost zero in the trial village. This clearly proved the success of introduction of 0.2 percent D.E.C. medicated salt for consumption by the community to control rural filariasis.

A detailed analysis of the reasons for the success of this project revealed that, apart from the felt-need of the community, the health education and community participation had played tremendously. Actually the health education and motivation to capitalise the felt need of the community were done step by step by the local filaria control agency (i.e.) National Filaria Control Unit, Chidambaram. The steps were as follows:-

## **INFORMING THE VILLAGE LEADERS**

First, the village leaders were identified. They were, the village panchayat president, the post-master of the sub post-office, the teachers of the village primary school, the social workers of the local voluntary agency called 'A code land' of Ulundurpet, who were serving there for the promotion of environmental sanitation and other public health aspects and the president of the voluntary agency who had got some influence over the village.

A meeting was convened with them. The basic facts about the disease and the merits of the medicated salt project were explained in detail with clearing all their doubts. They were much satisfied and motivated to be involved in the new project.

## **EDUCATING THE COMMUNITY**

Second step we did was, organisation of a public meeting in the village itself with the help of the village leaders. The acceptability of medicated salt, the absence of side-effects and the advantages of the project were stressed there. Besides, an appeal was made to them to be an example for the whole state by having the project in their village,



which was the first of its kind in our state. This factor of 'pioneership credit' carried over their heads worked well and motivated the community.

## **ORIENTATION TOWARDS THE PROJECT**

In continuation, series of film-shows were arranged, depicting the disease manifestations, complications, mode of spread, social stigma etc. so that the community could be oriented towards the disease, its seriousness and the significance of remedy. This was done continuously for 3 days and the people began to talk to each other about the new project to be launched, with hopes of relief from the stigma.

## **INDIRECT MOTIVATION & CREATION OF CONFIDENCE AMONG THE COMMUNITY**

In addition to the health education to the community for the above specific purpose, the filaria control unit, chidambaram was routinely doing education and service in other areas of the district. The services were, rural filaria survey and treatment, night blood survey and treatment in students' hostels and labourers' quarters, coverage of septic tank vent pipes with mosquito -proof nylon mesh, mosquito control focal spray against Japanese encephalitis, health education for the students and teachers of schools etc. These education and service activities came to the knowledge of this village people through local news paper and the voluntary agency. This in turn created confidence among the people and a strong trust with the project-implementing agency. This was one of the important factors which led the community towards participation.

## **CONVINCING THE SALT TRADERS**

After gaining the acceptance of the community, came the problem of motivating and convincing the traders. As identified, there were only three small traders of common salt catering the entire village. One was the main trader residing in the trial village and two others outsiders. Along with the village leaders, we met the traders and explained the proposed project. In the absence of any legal provision to make the salt traders to sell the D.E.C. medicated salt, the sole means were education, motivation and convincing. The outside vendors refused to participate in the project for fear of any bio-social problem, due to ingestion of medicated salt by the villagers, but simultaneously agreed to withdraw sale from the trial village. In one way, this became easy for us, leaving only one to be tackled. In another way, it became an



advantage for that only one trader to be the monopoly there-after. Hence the main trader of the trial village accepted to participate in the project.

Here one thing we must note. (ie) Actually in the process of medication done by the Govt. Agency 20Gm. D.E.C. was added with 10 kg. common salt, the whole mixture was put in the seed dressing drum, and rotated for a few minutes to get a thoroughly mixed medicated salt. During this process the salt became powdered. When this powdered and medicated salt was sold by the trader to the community by measures there was reduction in the number of measures when compared to the measurement of raw crystalline salt. So here practically the profit for the trader became lessened. Even then the trader not minding it, volunteered to co-operate.

## **COMMITMENT OF THE IMPLEMENTING AGENCY**

Apart from the acceptance of the village leaders, involvement of the whole community, co-operation of the salt trader there was strong commitment by the officer and staff of the implementing agency which was evident by their hard work and dedicated service. This was achieved more by leadership than small allowances.

## **CONTINUOUS INVOLVEMENT OF THE COMMUNITY**

After everything became acceptable and the project set in motion, it could not have been possible to continue, if any adverse reaction would have arisen out of ingestion of medicated salt. Except head-ache and myalgia reported by some old women, that too psychological, no other serious side-effects like vomiting, diarrhoea, fever, swelling or any allergic reaction were reported. This important aspect of absence of adverse reactions made the people to extend their participation throughout the period of trial.

## **CONFIRMATION OF THE CONTINUOUS PARTICIPATION OF THE COMMUNITY**

This continuous participation of the community was confirmed by taking periodical salt samples from the kitchen of the village as well as from the salt trader. Both were sent for analysis to the Regional Filaria Training Centre, Calicut and the presence of estimated amount of 0.2 percent D.E.C. was assessed. On assessment it was confirmed that the villagers consumed only the D.E.C. medicated salt. Though there were way and means to go to the nearest towns like Ulundurpet,



Thirukovilur or Ariyalur for purchase of commodities, they never bought any other salt from outside, except the medicated salt obtained from the village itself, medicated by the implementing agency and sold by the village salt trader.

## CONCLUSION

To summarise all the above, it was known very clear that though there were felt-need and health priority in a community, health information to the community, health education of the community, motivation, acceptance and participation were very essential. Here the community participation following the health education has had great impact on the project in controlling rural filariasis. Especially, before, venturing an experimental project directly related to the Biology and Sociology of a rural community with limited literacy as in this case of D.E.C. medicated salt project, in a rural village, not only health education and community participation essential but also the co-operation of publicity media and voluntary agencies, we learnt from this trial project and this lesson is projected here for your information and thought through this presentation.

## REFERENCES

1. Narasimham M.V.V.L., Sharma S.P., Sundaram R. M., et. al Control of Bancroftian Filariasis by DEC Medicated Common Salt in Karaikal, Pondicherry, India, J. Com. dis. 21:157
2. Krishna Rao Ch., Sundaram R.M. et. al. Control of Bancroftian filariasis with DEC Medicated Salt in open communities in Rural & Urban areas J. Com.Dis.8.193
3. Rao C.K. R. P ., Russle S., Hamzakoya K.K., et.al. Control of Bancroftian filariasis with common salt medicated with DEC in Lakshadweep Indian. Med. Res. 73:865
4. Informal consultation : TDR/FIL/PEN/92.3 DEC Medicated salt in the control of Lymphatic filariasis.



# LESSONS FROM SOME CASE STUDIES OF COMMUNITY BASED PROJECTS

*Mrs. Shantha Narayanan*

The UNICEF assisted community based Nutrition project, Alappuzha Kerala linked to UBSP, and nine other NGO projects in TamilNadu were studied as part of an exercise by UNICEF, Madras field office to develop a training module on 'community Nutrition' for officers and supervisors of Nutrition Programmes in Tamil Nadu. The objective was to identify and analyse the factors contributing to success/failure of these community based efforts. The projects studied included:

1. The community based Nutrition Project, Alappuzha Kerala
2. Centre for rural Health and social Education, Tirupathur, North Arcot Ambedhkhar District
3. Tirupathur Rural Uplift Project Association, pasumpon Muthuramalingam District
4. ASSEFA-Plan International, Uthiramerur, Chengai- MGR District
5. Social life-Ambedhkhar District
6. Rural Bright Services and Medical Centre, Polur, Thiruvannamalai Samburvarayar District
7. Community action for Social Transformation, Nellai Kattabomman District.
8. Educational Upliftment Society for Rural downtrodden, Chengai MGR District.
9. Thirumalai charity Trust, North Arcot Ambedhkhar District and,
10. Rural Integrated Development Organisation, Dharmapuri

The genesis of the projects, the role of community, the Spectrum of activities, strategies for organising and mobilising community, training strategy were analysed.

The lessons that can be learnt from these projects are summarised here.

1. Poor people for whom the programme was being implemented were key actors and not just passive beneficiaries.

---

*Mrs. Shantha Narayanan, Deputy Director (Communication) TINP, Taramani, Madras-600113.*



2. Programme that organised the so called powerless or underprivileged people in to small groups, thus empowering them, results.
3. Successful programmes rely on local resources- human, organisation and economic rather than on external help.
4. External expert for implementation is not essential. Poor people know what is best for their own development, provided they have access to information and adequate resources.
5. Programmes did not implement a rigid package of interventions. A lot of 'adaptive programming' or planning in action is seen in successful efforts.
6. Smaller neighbourhood groups were more effective than groups covering vast geographical area with little or no day today contact.
7. Community participation was a means to empower and an outcome of empowerment. Active participation requires that communities are involved in programme planning, implementation, monitoring, and evaluation.

This includes assessment of the problem, analysis of the causes of the problem and the decisions regarding appropriate actions. Management of resources by Community was not only a desirable outcome but a key to success and sustainability from the beginning. When programmes cover areas larger than a few neighbourhoods or villages, Cluster Committees/Apexbodies or some form of organisational structure emerges providing support to the smaller groups. These community organisations will eventually be able to exert enough social pressure to get long term political and bureaucratic commitment.

9. Nutrition supplement is not the only answer to problem of malnutrition and successful programmes attempt much more.
10. Targetting the limited resources to the most needy is less of an issue when people themselves do it rather than when an outsider or Government worker 'chooses' a beneficiary for social benefits.
11. Just as "top down" approaches will not yield results in the long term, a bottom up process (achieve the same goals) cannot sustain or be effective enough to make impact on large sections or community without support of advocacy and social mobilisation from the top. Community based development programmes



should not therefore be planned and implemented in isolation from national programmes of the Government. They should rather be linked to these.

12. A well designed training programme that is flexible and need based is woven into these successful efforts. They are not one-time efforts but continuous and often may not even be termed 'training' and use a participatory/interactive approach.
13. Accountability and clear roles for all members/group is evident.
14. The process - how things are done is more important than mere inputs.
15. Simple but relevant information has been generated and used by the community.
16. Above all the executives/implementors were eager to participate with the community than just paying lip service to community participation or waiting for community to 'come and participate'.

Some of these projects were not without drawbacks. They were mainly as follows :

- a) Scale of operation was too small to make real impact on vast sections.
- b) Resources included large inputs from outside, hence may not be available to all communities all the time.
- c) These projects require very committed staff at all levels - which is tough to ensure when replicated especially in large scale Government efforts.
- d) No clear indications about evaluation was available and hence impact and claims cannot be accepted.
- e) Cost per beneficiary was too high.
- f) Only supplementary food was offered as a solution and hence impact will be low, considering the multifactorial causes for malnutrition.



# COMMUNITY INVOLVEMENT - TINP EXPERIENCES

*Mrs. Annie Valsarajan*

It is needless to say that community involvement is an essential component for the success of any developmental programme. Communication and Community involvement were the important components of TINP I. Communication input of the project tried to change the knowledge, attitude and practice of the target community towards better health and nutrition and the community involvement strategy/ helped the community to shoulder more responsibility towards the projects than merely receiving and accepting the services.

TINP I was Launched in one block of Madurai District in 1980 and was extended to 173 rural blocks covering 11 districts of TamilNadu with the world Bank Assistance. The objectives of the project were to bring down the infant and maternal mortality, improve the health & nutrition status of antenatal & post -natal mothers & children below three years, and change the household feeding practices of mothers. To implement the services, community Nutrition centres were opened in each village (for every 1500 population) and a local mother with a basic education of X Std. was selected, trained and posted as a community Nutrition Worker (CNW). Tasks include growth monitoring of all children below 3 years, selective supplementation to the children and expectant mothers, administration of vitamin 'A' solution, deworming of children, provide supportive services to Village Health Nurse for delivering mother and child care services, distribution of O.R.S. packet and provide health and nutrition education to mothers.

The CNWs job training equipped her to be an effective Communicator and a Community Organiser. In each village, the CNWs formed womens working groups and children working group. The members of the womens working group were the influencers and motivated women drawn from a cross section of the village community in order to be a link between the community and the project. The total members of the groups depended on the total numbers of families in the villages (one representative for every villages)

---

*Mrs. Annie Valsarajan, Joint Director (Communication) TINP,  
Madras 600113.*



The children's working group comprised of 25 to 30 children in the age group of 8 to 12 years selected from the local school with the help of the teachers. Regular information sessions were held for the members of womens working group which included a once a month cooking demonstration sessions. Similarly the CNWs met the children's working group members and taught them Health & Nutrition messages.

Both womens working group and childrens working group were involved in the project implementation mainly for disseminating project messages and encounter problems in implementation. As a result the project 1 brought down the severe malnutrition to half and prevented many risk children from becoming severely malnourished. In spite of following very rigid selection criteria for food supplementation, the response for the regular growth monitoring was encouraging. The project proved to be cost effective, and replicable community nutrition programme.

When the first project was wound up in 1989 the Tamil Nadu Government came forward to extend the programme to the non TINP area with the World Bank assistance. Thus in 1991 the TiNP II came in to operation in 11 blocks of Madurai District. In a phased manner, the project is to cover 316 blocks in 19 rural districts.

The second project will cover children from 0 to 6 years, ante-natal and lactating mothers. Besides, Health and nutrition intervention, the second project will implement noon meal programme and pre-school education. The chief Ministers noon meal programme which was functioning separately will be merged with the TINP programme and hence each centre will have 2 workers namely the CNW and Child Welfare Organiser (CWO). The CNW will be responsible for all the activities of children below 3 years and CWO will look after noon meal programme and pre-school education.

The second project will give more emphasis on involvement of community in the programme. Thus each CNC village will have an adolescent girls working groups besides the womens working group and childrens working group. These groups will be motivated and trained to shoulder more responsibilities in planning, implementing and monitoring the programmes.

At present the project is under operation in 15 districts covering more than 15,000 centres. Some of the strategies followed in enlisting Community's involvement are as follows :



## **1.EFFECTIVE TRAINING FOR FRONT LINE WORKERS**

After selection, the Community Nutrition Worker (CNW) who is the nucleus of the project undergoes a need based job training for a period of 8 weeks. Being a decentralised block level training this training equips the Community Nutrition Worker to be a Nutrition and health Communicator as well as a community organiser. The training helps the worker to modify her attitude towards working with people and through people for a successful implementation of the programme and creation of a 'self help' attitude among Community to achieve better maternal and child care.

## **2.PREPARATION OF THE COMMUNITY BEFORE PROGRAMME IMPLEMENTATION**

During the last seven days of the job training the Community Nutrition worker prepares the Community for the project launching. The Community preparation exercise includes understanding the Community- i.e the resources, Leadership, Knowledge, attitude, values, practices, problems and needs of the village. The CNW identifies suitable members for womens working group, Childrens working group and adolescent girls working group respectively and forms these groups. On the last day (7th day) a leaders training camp is organised and the salient features of the project such as objective and programmes are explained to the opinion leaders. The Community groups (womens working group, Childrens working group and adolescent girls working group) along with the local leaders launch the project in each village. This exercise helps the Community to understand the details of the project and their role in the programmes.

## **3.SYSTEMATIC WORK ROUTINES FOR THE WORKERS**

A weekly work routines schedule is evolved for the workers, which gives clear directions for the workers to do specific work every day. This helps the CNW as well as the Community expect the V.H.N's visit to the village and her special activities such as mothers day, Childrens day (immunization) etc. This work routine provides an opportunity for the Community to plan the programme with the CNW and VHN, assist in implementation and monitor the progress of the programmes.

## **4.INVOLVEMENT OF COMMUNITY GROUPS**

Regular monthly once meetings are held for the Community groups by the CNW. These meetings not only provide an opportunity



for the Community to learn all aspects of mother and child care but also participate in the planning and monitoring exercise with the CNW. Hence the members of these groups become partners of the programmes.

The womens working group members are able to influence the non acceptors of growth monitoring specially in the new districts. They are able to identify the ante-natal mothers during the early stages and report to CNW/VHN Which helps in improving the coverage forearly registration. In some areas the members have come forward to distribute the food suplement to the beneficiary children and mothers specially in uncovered hamlets. During the intensive education programme, the members follow the "each one,teach one, change one" strategy and successfully reach out and influence of the non acceptors and non adopters.

The Childrens working group helps the project as noise makers; go round the village shouting slogans and holding placards before important events in the village such as growth monitoring sessions and immunization campaings etc, The project messages are disseminated to their peer group, and parents very effectively.

The Childrens working group and adolescent girls working group together form cultural groups. They are trained to be excellent group for disseminating project messages by performing folk programmes such as Villupattu, Puppet show etc.

## **5.SPECIAL TRAINING FOR COMMUNITY GROUPS**

Besides the regular monthly meetings, TINP will impart special training for a few representatives of each Communitygroups from each village involving the non Government organisation. It is expected that these special training which will be held at sectoral level will enhance the leadership qualities of the members to be good planners, implementers and monitors of the programme.

## **CONCLUSION**

Though the need for Community involvement is well recognised by every one, it is considered to be the most difficult endeavour. Inspite of being a large programme covering a vast area the experiences of TINP in involving the Community has yeilded fruitful results. The secrets of achiving the success is the CNWs who are highly motivated and are well trained to be effective communicators and Community organisers. The administrative support and allocation of sufficient funds towards this purpose has also made this project replicable and successful programme.



# COMMUNITY PARTICIPATION FOR WOMEN AND CHILD HEALTH PROGRAMMES

*Dr. Sumathy S. Rao*

## INTRODUCTION

Mothers and children constitute nearly 70 per cent of the region's population. The prevailing infant and maternal mortality rates range less than 30 to more than 90 per 1000 live births in respect of infant mortality, and 1 to 10 per 1000 births in respect of maternal mortality. It has been demonstrated that both infant mortality and fertility rates can be reduced through an integrated MCH/Family Planning Service at all levels of the health infra structure. The child survival and safe motherhood Programme will also have beneficial results in reduction of both infant and maternal mortality.

All member countries of W.H.O have taken series of steps to improve women and child health through delivery of integrated health services programme. The overall objective is to achieve the goal of health for all by 2000 A.D. Though countries have made some progress in this respect, much more remain to be done. There is a wide gap between knowledge and practice. Health planners and social scientists are agreed that this gap could be reduced through public participation, particularly of women, in various phases of planning and implementing the programme. There is thus a great need to promote concerted efforts aimed at enlisting participation.

It has been the experience that primary health care programme should receive continuous support of education and communication for its success. "Human Nature", as Bertrand Russel has said, "is at least nine-tenth genetic". The nurturing of human nature depends largely on education through information and persuasion so that they adopt certain ideas and practices which enrich their life. Whether it is education or communication, there are three factors involved in 'nurturing' :

- a. the target (direct targets like mother and child or indirect targets like the influentails or promoters)
- b. the media (the mass media or traditional media) that would reach the targets directly or indirectly.

---

*Dr. Sumathy S.Rao, Secretary, TAMILNADU CHAPTER, SEARB, Y-37, Anna Nagar, Madras-600040.*



- c. the message (what to convey to each of the targets and in what creative form)

Though the people central to the promotion of health of mother and child and media to be employed are essentially the same, the messages are to be tailored in order to meet the needs of the programme. Combining of messages for convenience would result in the loss of focus on both.

## **COMMUNITY PARTICIPATION FOR MOTHER AND CHILD HEALTH**

Promotion really brings true participation when the people involved decide what needs to be done and particularly what needs to be done first. An educated public is essential to the achievement of health goals. The task of the health educator is to function as an effective link between people, professionals and policy-makers.

The central aim of community involvement is to influence the target population so as to promote a process for social change. Public Involvement cannot occur without understanding. Communication and education, therefore, will determine the success or failure in public health, henceforth. Health professionals and communicators shall understand each other and fill up the communication gap.

Dr. U.Ko Ko Regional Director, said: Community Participation and involvement in Primary Health Care (PHC) was essential to attain the goal of self-reliance and self-sustainability.

Among the supportive activities, identified for the successful implementation of PHC are successful community involvement and participation, intra and inter-sectoral coordination, mobilization of resources and development of health manpower.

Health is not a felt need of the people, while getting cured of illness is. Education for health has to recognize this basic reality and try to change the attitude of people towards health care from passive indifference to active concern. This is possible only if the people are persuaded to perceive an immediate personal gain in adopting the suggested course of action.

## **EDUCATION FOR COMMUNITY PARTICIPATION**

The educational campaign, has to address the target's keeping in mind the nature of their concern on the issue and design the



messages on credible premises to meet their need. Transferring the concern into a felt need according to the characteristics of the target is the function of communication and education.

## **PROGRAMMES AIMED AT WOMEN**

Women, for example, are the primary target, which for the purpose of education and communication, can be divided into two segments on the basis of their concern viz premarried and married women. This segmentation will help in having homogenous groups so that the media can be sharply focussed on each and the message can be meaningfully positioned to hit the target.

### **TEEN-AGERS**

Studies have shown that the mortality rate is considerably higher among women who become mothers at young age. A campaign with factual and emotional appeals addressed to the girls in schools and colleges will help in persuading the young women resolve against early marriage and early motherhood.

The campaign for this segment should also highlight the health needs of teen-age girls, improvement in nutritional habits, social development aspect of women, the role of young women in influencing illiterate married women to adopt health care measures etc.

The success of the message depends on how creatively the facts are put in appeal and how emotional appeals are 'positioned' so that they acquire the 'drive force' needs to move the target in the desired direction. Creativity is what matters.

As the target is the young women in schools and colleges, print media will be effective. Well-written and illustrated folders which treat the young women as responsible people who are at the same time decision-makers in their own affairs and influentials at home and in the community, will educate and persuade.

Press advertisements and sponsored articles in women's magazines of different regions will be effective.

Radio and TV can carry the relevant information in the youth programmes and plays, stories, quiz etc. in the general schedule.

### **THE MARRIED**

The campaign addressed to the other segment, the married women also should be both educative and persuasive. The target of



this campaign is wider because of the socio-economic and life-style difference among women living in rural areas, urban slums, tribal areas, factory workers, agricultural labour etc. Culture, customs, religion and rituals and their role on food and nutrition and on mother's health are the other factors to be taken into account while designing the message strategy.

Because of the differential in the message requirements, the creative and media strategies would dictate broadly two different approaches in the campaign.

a. A general campaign addressed to women to (i) bring home the recommended nutritional habits, particularly of expectant and lactating mothers, (ii) promote family planning practices to reduce maternal morbidity and to improve child survival (iii) Popularize immunization of women, especially expectant mother with tetanus toxoid (iv) make them aware of the adverse effect of heavy work on pregnant and lactating mothers and (v) help appreciate the need of making use of the medical facilities available in the locality etc.

Being a general campaign, this should feature on mass media like radio, TV and film. The creative strategy is to dramatize and personalize the message to make it emotionally and factually appealing to the targets and influentials. Questions relating to the health care of mothers should be introduced in quiz programmes.

b. localized campaign should take into account the life styles of the community, ii) prevailing practices of pregnant and lactating mothers iii) social cultural, religious and economic factors in relation to mother's health etc. The most appropriate media for this campaign are the traditional forms of performing arts popular in the region. Every region has its own folk theatre forms which have been entertaining and educating people for years.

An illustrative example is a 'katha' presentation in Andhra Pradesh which for the last several decades has been educating the rural women about the health care of pregnant women through a story with songs and dance and a liberal dose of humour. Imaginative scripts should be got written for the traditional media of various regions and local troupes should be given incentives to produce them in villages. Most of the State Governments have their own Song and Drama departments, who also should be persuaded to present such programmes at fairs and festivals in rural areas.



Creative programmes like plays, songs etc. broadcast over the radio and also the ones produced exclusively for cassettes may be played at public places as frequently as possible.

T.V. and film programmes on mother's health may be video-taped and given to mobile units of Field Publicity Department for screening in their regular programmes.

Well-written Folders containing factual information about the existing health status and nutritional needs of pregnant and lactating mothers, immunization of mothers, primary health care facilities available locally etc. should be supplied to social workers, mass media personnel and women's organizations. Effective posters telling the story visually may also be distributed to Anganwadi workers, family education centres, hospitals, Mahila Samajam etc.

The element of 'drive force' in a message is the appeal. In health communication, studies have shown, the most powerful drive comes from fear arousing appeals, discretely used. The fear arousing appeal creates a dissonance in the mind which should be immediately set at rest by credible suggestions of a course of actions which prevent or cure the diseases.

**Influentials/Opinion Leaders :** Camps and workshops for women leaders, social workers and other activists in rural areas may be organized frequently either through voluntary agencies or the official health agency at local level. This can be done as a coordinated effort of health, social welfare, adult education and other government agencies working at Block level. Filmstrips, slides, portable exhibits etc. on various aspects of mother's health may be used on each occasion for effective education and motivation of participants who are the channels of two-step flow of communication.

**Education and Involvement for Health of Child:** The International Declaration of the Rights of Child states that "Mankind owes to the child care the best it has to give". We have only acknowledged this debt by placing child health and child care at the core of efforts for national development as stated earlier.

Protein malnutrition is an important cause of infant and young child mortality, stunted physical growth and low output. The wide spread occurrence of protein malnutrition among children and expectant and nursing mother's spells grave danger to the development of physical and mental faculties of the population. Damage done by



malnutrition during the first four years of life critically affects the intellectual growth of the child, besides causing various physical ailments such as blindness, goitre etc.

Dairrhoea, another major cause of mortality of children under the age of five, is caused by personal and environmental insanitation. Nutritional blindness is another big threat to the children.

These are among the many serious threats to the life of our children. Most of them are 'needless problems' because they are there inspite of being preventable and they cause disablement or death inspite of being curable.

Central to the promotion of child health are:

Parents

Schools

School Workers

Mass media operators

Health Workers

Opinion leaders and

Children themselves

The above are the targets of communication. Some of them are targets as well as media for further communication. Several other media also may have to be put in to reach all targets, depending on where the targets are and what has to be communicated to them.

## MESSAGE

What do we want to communicate? The message of the campaign should relate to the following areas:-

1. The infant mortality rate-its magnitude and meaning.
2. Child-bearing and rearing practices.

(Nutritional practices, custom and habits of pregnant women in different societies; child rearing practices such as breast feeding, weaning food, child nutrition, bottle-feeding, growth monitoring, personal and environmental cleanliness, regular habits, parental attention etc.)

3. Immunization : Lack of facilities and lack of interest in making use of available facilities; how immunization has saved millions of children.



4. Prevention and management of common childhood ailments: Diarrhoea for instance, has been the deadliest killer of children though it is preventable and easily manageable if the parents or others at home would care. Breast feeding, personal and environmental cleanliness, use of ORT to prevent dehydration are to be promoted; bottle feeding to be 'discouraged'.

Methods for prevention and control of worm infestation are to be promoted in rural areas. Measures to supply safe water and sanitary disposal of human and animal waste would prevent diarrhoea, worm infestations, cholera, Jaundice etc.

5. Nutrition Disease caused by nutritional deficiency; the damage caused by nutritional deficiency to the mental and physical development of the child; promote awareness among people about the nutritional value of locally available foods; impress on the people that nutritious food is not expensive food.

Media : Once the targets are identified and the communication points of what to tell and whom are determined, the media and creative strategies can be decided.

Selection of a particular medium or a combination of media depends on various factors such as the reach of the media on the particular target group, the nature of the media (whether it is an awareness creating media or persuasive media) and the nature of the message.

Much is known about how to employ the conventional mass media such as radio, TV, film and press and hence I do not propose to deal with what media should be used to reach which of the targets mentioned above. I would lay emphasis on the creative expression of the messages -factual and emotional aspects of presentation.

Printed material such as illustrated folders, posters, film strips and slides to be used as Seminars, workshops, camps etc. for the benefit of teacher, social worker, health workers and others.

Self suggestion to children through nursery rhymes, short stories, playlets to be encouraged.

Writers should be encouraged to produce such materials. Competitions, writers' workshops etc. should be organized to get good pieces written ; attractive award should be given for good material. Nursery rhymes on various aspects of child health will have lasting impression on children.



Attractively produced folders on child and mother health may be distributed to children in schools so that they carry them home. Teachers should be persuaded to explain the contents to children so that they in turn explain to their parents. The children, thus, will become informers and influentials at home and in the community. In illiterate homes, the children going to schools will have better influence and credibility and the new ideas and practices brought by them would be more acceptable.

Children's week like the mothers' week : A children's week should be arranged every year to focus attention on child care. Imaginately planned, the week will become an effective means of community education and participation. This will also be the occasion to present plays, songs and other creative items to educate the community through entertainment. If coordinated properly the mobile units of various departments including the Field Publicity Department can be involved in the week-long activities in rural areas.

The potential inherent in the people's participation and initiative for child development has to be fully tapped. This would become possible with the cooperation of paramedicals and health workers in rural areas. They have to be activated by the voluntary workers through their dedicated service.

If health professionals, communication specialists and social workers work hand in hand, a mother and child health revolution can be created in our country. What is needed is the Will; the skills are there. To 2000 A.D. there is only a short time left and we have a long way to go.



# IMPACT OF HEALTH EDUCATION ON MOTHERS IN A CAPTIVE POPULATION

## - A HOSPITAL EXPERIENCE

*Dr. A. Parthasarathy*<sup>1</sup> *Dr. B. Padmavathi*<sup>2</sup> *Dr. Radha*<sup>3</sup>  
*Dr. Rajamani*<sup>4</sup> *Mrs. C. Rajammal*<sup>5</sup> *Dr. M. Santharam*<sup>6</sup>

## INTRODUCTION

ESI Hospital Coimbatore is a referral institution with a total bed strength of 500 ; of which 60 and 34 beds are occupied by Obstetrics and pediatric cases respectively. The hospital caters to the referral needs of 34 dispensaries in and around Coimbatore city and acts as a referral institution for the ESI Dispensaries located in Pollachi, Udumalpet, Palladam, Tirupur, Mettupalayam and Udthagamandalam.

## MATERIAL AND METHODS

During the period from Sep. 1992 to 1993 Aug. 984 antenatal mothers have been registered and each mother had a minimum of 3 to 5 antenatal visits. Antenatal care includes health education, Injection TT immunisation, Anaemia prophylaxis, and preparation of the mother for breast feeding. 788 deliveries have been conducted and 764 live births were registered during this period.

The concept of "five cleans" (clean surface, clean hands, clean Cord Tie, clean razor blade and clean cord stump) was followed by using disposable delivery kits (D.D.K), whenever home deliveries are conducted, by stressing during antenatal check-up.

Detection of simple danger symptoms like Oedema feet, tiredness, giddiness etc., as warning signs of maternal complication, apart from routine urine exam, BP, Hb% and weight check up are carried out.

During delivery, the mothers are motivated for birth spacing, timing, limiting, early initiation of and exclusive breast feeding. The importance of good nutrition for the lactating mothers, proper care of new borns for weight gain, minor illness and other problem and about

---

<sup>1</sup> *Pediatric chief*

<sup>2</sup> *Pediatrician*

<sup>3</sup> *Obstetrician and Gynaecologist*

<sup>4</sup> *Multipurpose health supervisor*

<sup>5</sup> *Superintendent, ESI Hospital, Coimbatore, 641 015 TN, India.*



the need for early immunisation coverage by starting Neonatal OPV, BCG, within 3 to 7 days after birth preferably before discharge from the hospital and also about the need for continuing primary vaccination at 6, 10, 14 weeks with DPT, OPV and measles vaccination between 9 - 15 months, which are later continued as booster dose at 1<sup>1/2</sup> year (DPT & OPV), DT at 5 Yr. and TT at 10-16 Years are given.

## RESULTS AND DISCUSSION

The impact of this sort of health education resulting in better health awareness is very encouraging and action oriented in a captive population consisting most of textile workers, industrial workers etc., when compared to general population seeking free medical aid as shown by the following observations.

**TABLE I**

**ANTENATAL REGISTRATION FROM Sep. 1992 to Aug. 1993**

Weeks of pregnancy	16-20 weeks	22-28 weeks	28-32 weeks	More than 3 visits
No. of women came of A.N. Visits	304	290	284	1016

**TABLE II**

**NO OF MOTHER WHO HAD INJECTION TT**

Total No. of Mother's Registered	I dose	II dose
984	984	984

**TABLE III**

**TOTAL NO OF LIVING CHILDREN**

Total No. of An Mothers	Less than 2 children	3-5 children	More than 5 children
984	769	115	9



**TABLE IV**  
**NO OF MOTHERS RECEIVED IF A TABLETS**

Total No. An Mothers	Mother's received 1st time 30 tab	Mother's received II time 30 tab	Mothers received III time (40 tab)
984	864	916	784

**TABLE V**

No. of High Risk Pregnancies	
Pre eclamptic toxemia	3
Anaemia	1
Accidental hemorrhage	2
Placenta Previa	2
Cephalo Pelvic disproportion	4
Twins	3
Eclampsia	1
Diabeties complicating pregnancy	1

**TABLE VI**

Mode of deliveries	
Natural deliveries	603
Forceps deliveries	31
Cesarean section	144
Total deliveries	778

**TABLE VII**

No. of Normal new born	No. of Babies resuscitated	High risk new borns refered to other hospitals
744	15	19

**TABLE VIII**  
**Incidences of L.B.W. Babies (less than 2.5 kg.)**

Total New born	Term LBW	Pre term LBW	Total LBW
778	59	48	107



**TABLE IX**  
**Average Birth Weight**

Total	Less than 2.5 kg	2.6 to 3 kg	3.1 to 3.5 kg	3.6 to 4 kg
778	107	382	264	25

**TABLE X**  
**Neonatal Immunisation**

No. of New borns	BCG	O-OPV
778	780	764

**TABLE XI**  
**No of Infants received DPT, OPV - measles immunisation**  
**Total Infants registered for Immunisation 236**

	DPT	OPV	Measles Vaccine
I dose	236	236	330 *
II dose	225	225	
III dose	221	221	* 94 were
I booster	196	196	outside
II booster DT	205	205	registered

Out of 778 infants who were born in ESI Hospital only 33% of the infants came for regular immunisation to the hospital. The rest of the infants who are located at far off distance from ESI Hospital had immunisation from nearby Municipality (or) private practioners.

**TABLE XII**  
**Promotion of Breast feeding**

Total	New borns fed at 1/2 hrs	New born fed at 2 hrs	New borns fed at 4 hrs	New borns fed after 4 hr.
778	Nil	312	398	78



The highlight of the impact of intensive health education to a captive population are :

1. Average Antenatal cases registered - 95%
2. Average Injection TT coverage - 100%
3. Average Institutional delivery - 95%
4. Average Birth weight of babies - 2.9 kg
5. Low birth weight baby - 107 babies (15%)
6. Total No. Breast feeding mother's - 762 mothers (98%)
7. Total No. of Infants with normal nutrition - 545 infants (70%)
8. Total No. of Infants with Grade I malnutrition 155 (10%)
9. Total No. of Infants Grade II malnutrition 78 (10%)
10. Total No. of fully immunised infants 90%

The Impact of intensive health education to expectant mothers has also resulted in an encouraging response as regards Family Welfare acceptance as, shown in the table below :

**TABLE XIII**  
**FAMILY WELFARE ACCEPTANCE**  
**TEMPORARY METHODS**

IUD	Oral Pills	Condoms
34	36	748

**PERMANENT METHOD (Female Sterilisation)**

Total no. of Mothers who had Sterilsation	After One child	After Two children	After Three children	After More than 4 children
505	16	427	61	1

## CONCLUSION

Intensive Health Education Strategy in a defined population helps to achieve action oriented results. The beneficiaries also keep on disseminating health awareness resulting in better utilization of service delivery.



## **Section III**

---







# HEALTH EDUCATION AND MASS MEDIA HOW TO COMMUNICATE EFFECTIVELY

*Drs. J. Hagendoorn.*

At this third conference of the South East Asian Region of the International Union for Health Promotion and Education it is an honour and a pleasure for me to give a brief report of the 3rd conference of the European Region of the IUHPE.

The International Union is composed of regions which together form a global structure supported by the office of headquarters in Paris (France). Each region has its own office, you here in South East Asia in Bangalore, we in Europe in the Netherlands. Each region holds a regional conference every three years. In Europe the third conference was held in Amsterdam, May 1993, with the theme: "Health Education and Mass Media: how to communicate effectively". The conference was attended by approximately 350 participants from 33 countries, among which 27 European countries and participants from Canada, India, Israel, Singapore, South Africa and the United States. The conference dealt with many aspects of effectively using mass media in health promotion in 7 key note speeches, more than 60 paper presentations, 45 poster presentations, a media market and a health award competition.

It may be clear to you that this conference which covered a broad range of topics, scientific studies and reports of field activities cannot be reported fully in 15 minutes. So I want to highlight some important aspects.

Two elements were central in the theme of the conference:

- A. communication by the media
- B. effectiveness of these programmes.

A. Communication is a central element in health promotion and education. Communication is a means to reach our goals and when you travel you have to know where you go to, but also how you want to get there. This is also the case in health promotion and education: we talk of safety, nutrition, child health, sanitation, HIV prevention. But how do

---

*Drs. J. Hagendoorn, Vice President IUHPE, Regional Office for Europe*



we want to communicate? Before we start we have to think over this question thoroughly and especially in using the media this aspect needs ample consideration.

B. Another element in the title is effectiveness. Of course we want our activities to be effective. But how effective are they in reality? Is all the effort and all the money put into health promotion and education worth the investment? This question is special relevant in Europe where the rising costs of health care are becoming a burden to the societies. In answering these two questions, we organized a conference which had to be attended by health educators, public health specialists, radio and Tv journalists, film and video producers and software computer programmers. Too often our conferences are only attended by health educators! We wanted to generate some cross-fertilization because we think a good marriage between health promotion/education and the media is very much needed.

Ladies and gentlemen, Europe is not India and I realize very well that our European approaches may differ a lot because the difference in our circumstances. But I am convinced that many approaches are quite similar and that a lot of media which cannot be used in your country at the moment will be quite possible in the near future. Technology is changing very fast, and especially the electronic media are getting cheaper very quickly. They will come within reach for many people in a very short time!

By speaking about electronic media I do not want to say that other media are useless or ineffective. On the contrary!

- Oral communication is the most human communication there is and when you succeed in establishing a good system of oral communication between parents and children, between peers and youngsters, between doctors, social workers, midwives, nurses and the people that form of communication will continue to be a basic one. The best health educators are those who are close to the people.
- Teaching and oral contact between parents, teachers and children are fundamental: story telling, role play, singing, they are very useful in communication.
- Equally printed materials will stay important: pamphlets, pictures, posters, slides. People who are not able to read can still use them.



- The press journals, periodicals have equal possibilities; they can have a powerful effect in spreading information.

By speaking about all these above mentioned forms of communication, we know for years their possibilities and I am sure you are using them extensively : they are mostly not costly and very useful.

As you know the radio is a powerful means for health education as well. I am sure that I tell you nothing new. Nationwide programmes are important, but don't forget the local possibilities of the radio. Perhaps not here , but in Europe regional and local radio are becoming very popular, giving information and covering local topics which are very much in the interest of the local community. Radio has tremendous local possibilities and local radio may be a counterforce against state wide or national wide radio broadcasting. It is important for health educators to have good contacts with radio reporters and programme makers.

Another important medium is the radio-cassette recorder, which can be used in personal contacts and in various places, where no electricity is available. Songs, talks, interviews etc . are popular among youngsters. Radio-cassettes can be used very well in health education.

Television has become a world wide medium, influential and invading in many aspects the family life. In many countries television was hardly existing some years ago and now has a coverage of most of the people. I do not have to tell you how important this medium can be. We are watching stations which are broadcasting world wide with their specific view on the news (mostly a western view with much sensation in it). In my view here lies a task for international world wide organisations to promote good information and to stimulate ethical codes in broadcasting. But television is also on state and regional level : tv- programme producers can be your supporters in the fight for a healthy public policy on regional level.

The same role played by radio-cassette can be played by video-cassette. It can visualise many things, it can show people on the spot films which are highly instructive and useful, Video recorders also are becoming very popular in many countries, not only in Europe, but in many Asian countries as well. Use the power of this medium.



An old medium, but used frequently on video cassette is the film. Film industry is powerful. Many politicians in India came from your famous film industry. So be clever and use the film, the entertainment film for the health messages. Perhaps a non-smoking film hero can set a trend? I know very well that it is hard to form alliances with the tv and filmworld, but be sure the cigarette and nutrition industry have them, - why not you?

Here I enter now in the realm of the computer. A computer has many possibilities, I will not list them here. But apart from storing information e.g. for libraries and for writing and printing texts easily they can be used for games and these games can be programmed with health education messages. Why not use them? Perhaps not here today but in future.

You can buy electronic games seperately from computer hardware. These games may be useful as well.

Latest developments can be found in interactive videoplayers, which are computerized videos with tremendous possibilities of storing information which can be used at request, or as a game. CD-rom possibility: whole libraries on a small disk with all necessary health information avialable on a small machine. They are one of the newest forms of technology not very much used yet in Europe.

Interactive television is on its way, where you can ask questions, films, information, etc. And your television set answers.

Ladies and Gentlemen, a whole range of possibilities, cheap and expensive. What can be said in general to use them? Is their use without danger? No, certainty not. In the Amsterdam Conference the following warnings were heard:

1. A medium is a tool, not an aim! If you chose the wrong medium, it is something as choosing the wrong road. You end up elsewhere! Each medium has its own pros and cons: think over their use very well before you start.

2. Good communication and subsequently the use of the medium has to be learned . It is not inborn to people, so train yourself and your colloborators in using them in the right way, the right place and at the right moment. It will enhance your sucess considerably.



3. Plan carefully your use of the media. As the success of all health education activities depends on good planning, the use of media should be planned extremely carefully. Otherwise they will fail you!

4. The effective use of the media will be enhanced using a combination of communication techniques. Try to involve personal, oral communication in the use of your media as well. Do not show in a ward a video film without giving the possibility for questions, remarks, etc.

5. The use of media, good communication should be based on good ethics: create no fear, just give the facts, be honest, do not blame the victims.

All these elements seem to be self-evident, but they are not! In general, there is an extensive sinning against these rules.

Ladies and gentlemen,

I have to finish. I only want to share with you one of the most interesting conclusion of the European Conference: We are witnesses of a revolution going on in the electronic media in the world and you may be confronted with it in a short time..

We are going from

- |                      |      |                           |
|----------------------|------|---------------------------|
| - mass communication | ---> | to personal communication |
| - broad casting      | ---> | to narrow casting         |
| - national           | ---> | to individual.            |

That means for the subject of this conference that woman and children can be reached by the electronic media much more easier than it used to be. They will become an important audience which can be targeted specifically in many ways! So ladies and gentlemen, make clever use of it!

And last but not least, you may think well, all these electronic media are not yet applicable in our Indian situation, where people are still too poor. Today, this may be, but tomorrow? The computer industry is developing very fast in India. In industry there is hardly any technical gap in computerization with industrialized countries anymore. You have to think over the use of electronic media today, in order to use them tomorrow.



# ROLE OF CULTURAL, INDIGENOUS MEDIA TO PROMOTE PEOPLES INVOLVEMENT FOR WOMEN & CHILD HEALTH AND DEVELOPMENT

*Dr.N. Murugesan*

## 1.INTRODUCTION

ALMA ATA Conferance concluded on 12th September 1978 in U.S.S.R declared that the people have the right and duty to participate individually and collectively in the planning and implimentation of their health care.

It also emphasised the importance of full and organised Community participation and ultimate self reliance with individuals, families and communities assuming more responsilities for their own health. Community participation in the recognition and solution of their health problems can be facilitated by support from groups such as local government agencies, local leaders, voluntary agencies, youth and women's groups, consumers and service organisations and liberation movements, as well as by accountability to the people.

- 1.1 In the light of the above declaration and emphasis, the limited efforts put forth in the field and experiences gained on the utilisation of cultural indigenous media to promote people's involvement for women and child health and development are shared in this paper.

## 2. ORIGIN, DEVELOPMENT AND CURRENT SITUATION

- 2.1. Traditional or folk media have the age of mankind and are part of life of people. Folk songs rendered by people covers the entire gamut of life from birth to death. There are songs suitable for various important occasions. Each word in these songs is full of meaning vibrant with life and embodied with spirit and emotion into it. People have innate liking and love for it. The feeling and sentiments associated with events were over the ages shaped in to various folk media taking advantage of the appropriateness

---

*Dr. N. Murugesan, M.A.Ph.d. Consultant,  
Leprosy MDT Project, South Arcot District.  
7 Mariasusai Nagar, Cuddalore - 7, Tamil Nadu*



of its affective appeal. Virtues were nurtured portraying the successful stories of mankind and mythology. Varieties of folk media developed based on the locations, facilities, habits and customs of the people. People with talents and skills in these art forms, took them as professions and nurtured them. People fostered them and there was a time that no event/function was held without some forms of folk media. With the advent of printed and electronic media these traditional forms gradually started fading away. However it is heartening that still rural people consider these folk forms as mother of all art forms. People in urban areas also have fancy for it since they get fed up of used-up electronic media. One Karahattam in Marina beach would pull more crowd than any electronic media.

2.2 The cultural, indigenous media used for health/development communications vary from place to place. In general, cultural songs, Kathakalakshebham, puppetshows, Ratham, Karahattam, Villupattu, Kummi, Kolattam, Street theatres, folk dances are used in central and northern parts of Tamil Nadu. There are Professional groups, amaturish and indigenous groups to perform and give life and spirit to these traditional media.

### **3.EXPERIENCES**

#### **3.1.ADVANTAGES OF PROFESSIONAL GROUPS**

- i) The profesional groups are adept in their execution and performance.
- ii) They are sharp and smart. Their understanding is of high order.
- iii) Only few traditional musical instruments needed.
- iv) They have timing sense and presence of mind. These applications enrich the effectiveness of communication, keep up tempo and interest throughout.
- v) They are alert and look for entry points to get in to the subject mode and there will be clarity of communication.
- vi) Change in the troupe members don't affect the flow, continuity and the content of the performance.
- vii) They are big crowd pullers.
- viii) People are excited to watch live performances.
- ix) Upto date current messages in the colloquial language which are very local help identification with performers.
- x) People have regard for nativity that appeals at personal and intimate level.



## **3.2 PRE REQUISITIES**

- i) The profesional groups should be primarily interested in Health/ Developement communications. Mostly they are entertainment oriented groups.
- ii) They should be committed to social cause.
- iii) They should not be interested in monetary benefits only
- iv) They should primarily think that they are part of Community and they are responsible for Community Health programme and communication programme should be on partnership basis with people and service providers.
- v) There should be family like relationship between the troupe people & service providers.
- vi) These groups should be given orientation on subject matter, focus and objectives of the programme and target audience.
- vii) Everyone in the troupe should get very familiar with the subject and they should internalise the contents.
- viii) A sketchy scripts/ story should be prepared based on real field experiences.
- ix) There should be rehearsals trials and retrials conducted before they are engaged to give performance.
- x) These professional groups should almost become part of service providers/ field staff.

**3.3.** In South Arcot and Salem Districts, various traditional troupes were identified, given opportunities to know the programme by field visits and observations. Discussions were held on the subject matter. Rehearsals and dress rehearsals were done. Feedback was given and scripts modified and finalised and used in the field of all the traditional media; the following are found to be popular:

- i) Karahattam
- ii) Puppetshow
- iii) Villupattu/cultural songs.
- iv) Ratham.

## **3.4 PEOPLE'S INVOLVMENT**

These professional troupes during the process of performance, involve people and people take roles along with other performers. By this, distance between people and performers get



reduced and they become one among people. The service providers ie. peripheral workers are brought to the stage and they are given importance and roles explained, felicitated by the troupes. By this, the troupe becomes part of service delivery.

**3.5** Through these mass media, interactional communications are also tried. There are questions and answers sessions in between. Alert audience come out openly on the stage and educate the other audience. These initiatives are appreciated in the stage.

These troupes are not just deputed to conduct performance in village. It is based on people's initiative, demand and willing participation on partnership basis.

- Puppetshow has been successfully used by us for immunisation, O.R.T, breast feeding, Family welfare and girl infanticide and leprosy.
- Karahattam has been used widely to disseminate information on Immunisation, sanitation, breast feeding, Kitchengarden, nutrition, AIDS & Leprosy.
- Ratham - was used across South Arcot District combined with karahattam for a fortnight for leprosy. Mobile publicity was given to create awareness about the early signs of leprosy, efficacy of Multi Drugs and service facilities. People, voluntary groups, service organisations supported totally and its immediate impact was detection of Twelve new leprosy cases.
- Villupattu has been used for MCH & F.W.
- Cultural songs cover a wide range of subjects right from social evils, health & developement.

Of all these, though there are advantages and limitations for each media karahattam tops the list in its effectiveness.

In South Arcot District alone since January '93 to December '93, 95 karahattam performances have been done, with community support on leprosy. The people sponser the programme. Sponsorship includes arranging publicity, stage, loudspeaker, light, food for the troupes etc., skin camps conducted with a pre karahattam programme has always yielded very good results in terms of case finding and regularity of treatment.

The same troupe is now used for AIDS awareness programme also.



A small systematic study done on the communication effectiveness of karahattam revealed the following results:

- People have got clear messages on early signs of leprosy, curability and treatment facilities.
- People have changed their perspective on deformity and dealing in the leprosy patients.
- People also have realised their roles in National Leprosy Eradication Programme.

The demand for the karahattam among leprosy system and people is so high, troupes are not able to cope with. Efforts are now on to develop few more troupes with similar quality of performance.

### 3.6 INDIGENOUS MEDIA & PEOPLE AS PERFORMERS

In addition to preparation and use of Professional groups, efforts are also put forth to identify local talents and use them for health/development communications.

The following are the media tried with amateur community members :

i)	Kummi	-	Selected theme songs on MCH,F.W & Leprosy
ii)	Dances	..	-do-
iii)	Chorus children	..	-do-
iv)	One act plays/Dramas		-do-
v)	Villuppattu/Cultural songs		-do-

- Though there is no professionalism in these groups, they attract crowd, since the performances are from the same community.
- These groups are oriented on some specific subjects and learn the contents and perform. These messages may be very useful for disseminating the same in future also.
- There is no financial involvement for these performances.
- Identified and recognised hidden local talents come to limelight and they pursue further to develop their talents.

People own these media and they are local; Have sentimental attachment to this; They are live; Affect their emotions; change knowledge and attitude; Induce thinking faculty and ultimately produce change in the behaviour.



# MEETING THE CRITICAL, NUTRITIONAL NEEDS OF UNDER THREES IN THE ARF (AMYLASE RICH FOOD) PROJECT

*Prasadika Rathod*

## INTRODUCTION

Growth faltering of infants during 7-9 months due to inappropriate weaning is highly prevalent in all the developing countries resulting in stunted growth.

Weaning poses a problem due to infants' high nutrient needs and a small stomach capacity. The customary cereal gruel fed to Weanlings in India is viscous and less nutrient dense.

After extensive research a simple village level technology has been developed which promises to solve the problem of Protein Energy malnutrition. Malted cereal flour has the capacity to reduce the viscosity of cereal gruels from thick spoonable consistency to a thin pouring one which is easier for the child to swallow. Malted cereal flour is rich in the enzyme alpha amylase which reduces the viscosity of the gruel. It is therefore called ARF (Amylase Rich Food). Extensive research has been done on the use of ARF in Young Child Feeding by the Food and Nutrition Department, M.S. University, Baroda. (Further details on A.R.F. are given in Annexure).

In several national and international workshops on the dissemination of ARF technology, it was suggested that it has potential of being prepared at various schemes and levels ranging from households, rural/urban community centres, government sponsored schemes such as the I.C.D.S. and commercial market production. Therefore it be extended in various schemes and the technique be taught to the women workers in the programme. ARF is being introduced into a two year pilot project by the Department of Women and Child Development (DWCD), Government of Rajasthan on an experimental basis in 5 I.C.D.S blocks.

---

*Prasadika Rathod*

*Chetna, Lilavatiben Lalbhai's Bungalow, Civil Camp Road, Shahibaug, Ahmedabad - 380 004.*



## **PROGRAMME PLANNING, IMPLEMENTATION AND EVALUATION**

The programme has been jointly planned by DWCD, GOR and United Nations Children's Fund with technical support from Prof. Dr. Tara Gopaldas of M.S. University, Baroda. A bench mark survey has been conducted by Home Science Colleges of Jaipur and Udaipur. They will also conduct a final survey which in addition to monthly reports and 6 monthly evaluations at the anganwadi, block and state level will serve as an evaluation tool.

The successful components of the programme will then be integrated into the I.C.D.S. programme and the decision to extend/not to extend the programme to other blocks will be taken.

The functionaries of Integrated Child Development Services (ICDS) and department of Medical, Health and Family Welfare Services (DMH&FWS) are responsible for jointly implementing the programme. Based on its rich experiences of over a decade in Health Education, CHETNA was invited to give input in the Nutrition and Health Education strategy, to conduct Training of Trainers and develop the instruction manual and Nutrition and Health Education Calendar.

### **OBJECTIVE OF THE PROGRAMME**

The basic objective is to evolve a feasible and practical model for strengthening health and nutrition services for the 0-3 age group in ICDS in Rajasthan and for increasing coverage of this vulnerable population from existing levels to atleast 70% by end of 1996.

### **SPECIAL FEATURES OF THE PROGRAMME**

1. Delivery of services through a single window approach - The following services will be provided:
  - (a) Fortnightly distribution of food supplement alongwith ARF. This is the first time food will be given to take home.
  - (b) Community based production of ARF will be done by DWCRAs (Development of Women and Children in Rural Areas) women.
  - (c) Distribution of iron supplement alongwith 'take home food' every fortnight for 100 days/year
  - (d) ORS packets will be made available at the anganwadi
  - (e) Six monthly campaigns for deworming and administration of Vitamin A solution will be held.



## 2. MUTLI-LEVEL TRAINING

The training has been done at three levels-state, project and field levels.

DWCD, UNICEF, CHETNA, DMH & FWS AND MAHARANI COLLEGE, JAIPUR

TRAINING OF TRAINERS

### STATE LEVEL CORE TEAM

TOTAL NUMBER OF PARTICIPANTS	:	25(5 members from each block.)
PARTICIPANTS	:	<ul style="list-style-type: none"><li>* Child Development Project Offficer (CDPO)</li><li>* Chief Medical Officer (CMO)</li><li>* Deputy Medical Officer (DMO)</li><li>* Assistant Project Officer (APO) DWCR</li><li>* Regional Deputy Director (RDD)</li></ul>

### PROJECT LEVEL TEAM

TOTAL NUMBER OF PARTICIPANTS	:	104
PARTICIPANTS	:	<ul style="list-style-type: none"><li>1. Lady Supervisors (L.S.)</li><li>2. Lady Health Visitor (LHV)</li><li>3. Mukhay Sevika</li><li>4. Pracheta</li><li>5. Medical Officer</li></ul> Primary Health Centre

### VILLAGE (ANGANWADI) LEVEL TEAM

TOTAL NUMBER OF PARTICIPATION	:	1370
		<ul style="list-style-type: none"><li>1. Anganwadi Worker (AWW)</li><li>2. Aux. Nurse Midwife (ANW)</li><li>3. Link Person</li></ul>



## ANNEXURE

ARF A Promising Technology for solving the nutritional problem of the weanling.

Growth faltering of infants between six and eighteen months due to inappropriate weaning is a major concern in all the developing countries. This growth faltering often occurs at a time when infants are offered supplementary solid foods in addition to breast milk. The resultant cycle of malnutrition and infection curtails the child from growing to his full genetic potential. The magnitude of protein energy malnutrition is evident from U.N. statistics which estimate about 50% of the world's 11 million young children to be malnourished. This high prevalence of malnutrition is associated with high mortality rates in infants and children, high morbidity rates and suboptimal child development. Weaning poses a problem due to high nutrient requirement and limited stomach capacity of the infant. The viscous gruel offered as first supplementary food in India is of thick consistency and low nutrient density. The availability of micro-nutrients from cereal diets are also suboptimal.

The cereal grains in the gruel swell on cooking and render even a 20-25% cooked paste slurry, dough like or very viscous. The challenge therefore was to reduce the viscosity of these traditional gruels by simple cheap and reliable household technologies.

It was hypothesized that a child would be able to imbibe more of his 'thinned' gruel per sitting and consequently increase his calorie intake.

Malting of cereals is one such household level technology which is feasible even in rural areas. Malted cereal contains large amounts of the enzyme 'amylase' which breaks down starch.

Therefore small amounts (about 5gms) of malted cereal is capable of acting as a catalyst to break down gelatinized starch in cooked cereal gruels and reduce the viscosity of the gruel sufficiently from thick spoonable consistency to a thin pouring one. This enzymatically active malted flour is referred to as ARF (Amylase Rich Food). ARF can be made from all cereals. Wheat ARF has the greatest amylase activity.



## **DISADVANTAGES OF THE CUSTOMARY GRUEL**

### **1. LESS CALORIES**

An average gruel contains 10% of solids or less by weight. It is estimated that the infant can only take 200 to 300 ml per meal. Assuming it is fed three times per day only 60 grams per day of food is received which provides about 900 Kj of energy and 5 grams protein/day (i.e. considerably less than requirements).

### **2. LOW AVAILABILITY OF OTHER NUTRIENTS**

The availability of protein, calcium and micro-nutrients particularly iron is low due to high phytic acid and tannin content of cereals.

## **POSITIVE EFFECTS OF ARF**

1. Reduced dietary bulk due to reduction in viscosity and a thin pouring consistency are more appropriate for the weanling to swallow resulting in greater intake/sitting i.e. a gruel containing ARF has a higher solids level without viscosity build up so it is more energy giving.
2. Easy digestibility and reduced gastric emptying time thereby increasing the number of feeds.
3. Considerable reduction in phytic acid and tannin content thereby increasing the bio-availability of iron.
4. Significant increments occur in thiamine (Vitamin B1) - (20%) riboflavin (Vitamin B2) (175%) and niacin (Vitamin B3) (30%) and pantothenic acid (190%) due to biochemical changes.

The cumulative effect of all these changes is a better growth promotion in infants.

Research on standardizing ARF preparation methods for all cereals has been done by the Department of Food and Nutrition, M.S. University, Baroda under the guidance of Prof. Dr. Tara Gopaldas.



# EXPERIENCE OF CELEBRATING NUTRITION WEEK WITH CHILDREN IN SCHOOLS OF AHMEDABAD.

*Ms. Mona Shah.*

Children should be involved as Partners for health. Basically because

1. They have a right to participate for their own health.
2. They are equal citizen as adults to be responsible for health.
3. They are open to learn and courageous to put learning into practice.
4. They have a potential of being effective Change Makers in the Community by their natural communication.
5. By working with children we influence three generations, parents, children themselves and their future children.

Food is one of our most important basic needs. Right from childhood and adolescence, food is important for proper physical and mental growth. However, proper information regarding nutritious and balanced diet has not yet reached many people which has resulted in blind beliefs and incorrect dietary habits resulting in a poor nutritional and health status. It is therefore critical to make people aware to their nutritional need and low cost nutritious recipes. Dietary habits are formed during childhood and therefore nutrition education should start with children. Children are the most enthusiastic recipients of health knowledge and, could become important messengers of these health messages. If children are imparted life useful health education through activity based participatory approaches, they would grow up to be healthy citizens. CHETNA, as a part of its nutrition and health education strategy takes the opportunity and celebrates significant occasions like World Health Day (7th April), Nutrition Week (1-7th September) and others concerning children and women. CHETNA this year-1993, celebrated the Nutrition Week in formal schools of Ahmedabad.

School is a best place for imparting health education to children, as a captive group is available there.

---

*Ms. Mona Shah, Chetna, Lilavatiben Lalibai's Bungalow, Civil Camp Road, Ahmedabad*



But formal education system is often non-responsive and consider children as mere recipients of school health services rather than as active partners. To change this scenario teacher training and policy change is required. While efforts go on in those direction, we also need to find strategies to respond to the need of health education to these children now. An orientation and sensitization meeting with principals and a subsequent two day training of teachers in initiating health education activities in schools and planning of the strategy for the same helped to motivate and equip the teachers. The teachers planned and conducted various health and nutrition related activities in the schools like poster exhibition, slide show, puppet show, role play, folk songs, elocution, essay writing, drawing competition games like snakes and ladders, electrogame, checking personal hygiene of children, lectures by Health Experts, organising health check-ups and so on. A total of ten schools participated and celebrated the nutrition week, about 60-70 teachers and principals were oriented and motivated to include nutrition and health education through activity oriented approach. About 15,000 children participated enthusiastically and were exposed to the nutrition messages.

As a follow-up of this activity a Health Fair is being organized in february.

This way by sustained short term interventions in formal system, teachers will be influenced into activity oriented education.

And before they realise the so-called structured formal education system will become flexible responsive to the health education needs of children.



# **A CAMP AS A STRATEGY FOR WOMEN'S HEALTH AWARENESS CHETNA'S EXPERIENCE**

*Ms. Jyoti Gade.*

## **INTRODUCTION / RATIONALE**

The concept of Primary Health Care (PHC) reflects an essential health care that is accessible, affordable and acceptable to every one in the community. This includes provision of nutrition, safe potable water, sanitation facilities, child health, family welfare, treatment of common ailments, immunization, prevention and control of endemic diseases and health education'.

Overtly, it gives the impression that it addresses women's health concerns. However, when seen in practice, it merely provides health services to women during her maternal period. There are hardly any efforts aimed towards listening to women's concerns and understanding and providing appropriate health services to prevent them.

In case of family welfare programmes our experience and dialogue with women highlights that women are not ready to go through repeated pregnancies. She is willing to adopt family spacing & sterilization methods. However, she always has apprehensions, fears and questions regarding its affection, her fertility and the occurrence of side effects of the spacing methods adopted. Any related side effects are not taken seriously, when articulated, and therefore, she continues to harbour irrationale doubts, questions and misconceptions about the family welfare programmes, its services and its effectiveness.

Similarly women's hesitation and inhibition due to social and cultural upbringing and the lack of suitable environment to discuss her gynaecological problems have also been accepted with such passiveness, so much so that women continue to suffer from pain, neglect signs and symptoms of diseases either without complaining or unknowingly. CHETNA's decade long experience of working with rural/tribal and urban poor communities highlights that women would like to discuss about the family planning methods and their gynaecological problems but in a non threatening friendly environment. There is

---

*Ms. Jyothi Gade, Chetna, Lilavatiben Lalbhai's Bungalow, Civil Camp Road, Shahi Baug, Ahmedabad-380004.*



therefore, a great need to value this need and provide an environment where women can discuss freely about their health problems and also plan suitable action towards ensuring positive health.

CHETNA has conducted two women's health melas (fair) to address this need. The positive experience of these melas may be adopted in existing community and specifically for women's health programmes.

Women's Health Mela - An innovative Training Approach for women.

This was the first effort of health camp in the form of a mela conducted during 1990. The event was organized with an objective to try out an innovative health education strategy for women. 150 women health workers participated. They were provided an opportunity to discuss different aspects of women's health problems and their experience towards community health. Other aspects covered in the mela were to encourage them to use traditional media for health education and provide facilities for gynaecological check-up and hemoglobin estimate.

During the event, an atmosphere of the mela was created by organisation of fun activities during the evening and night sessions. In the early morning, there were Yogic exercise, which were followed by group discussion. In the afternoons health check up was facilitated followed by the development of health education material.

## GROUP DISCUSSIONS

The focus of the group discussion was to understand the effect of socio-cultural, economic, religious and political factors affecting woman's health.

The outcome of the discussion helped to strengthen CHETNA's team's own understanding of women's health, that is women's health needs have to be viewed in an holistic manner and not in isolation to her social, cultural, economic and political situation in the society. Our understanding was reflected in the discussion of the experiences of the grass-root level workers. Today CHETNA's Women's Health and Development Resource Centre :CHAITANYA" is based on the same understanding that ***"women's health programme needs to be integrated, holistic, gender sensitive and realistic"***.



The major health problems and concerns affecting women namely anemia, leucorrhoea, problems related to menstruation, infertility and problems during pregnancy and delivery were discussed at length with a focus to understand the technical information and link the health problem with the social and cultural aspects.

## **HEALTH EDUCATION**

Health education being the major activity of health workers due importance was given. The health workers were asked to develop the health education media based on their traditional folk practices and present it. Also they developed health education material in the form of posters and charts.

## **HEALTH CHECK UP**

To utilize the opportunity of women collected at one place, it was felt worthwhile to conduct a gynaecological check up. This was our first practical experience in this direction. Though we were convinced that gynecological illness are a major health problem of women we felt the need to get first hand experience. Also we were not aware about the women's readiness to go through the check up during the Mela.

Surprisingly we found that women were ready to go for the check up. Though in the beginning the number was small, once the check up began the number requesting for the same increased. It was not possible for us to handle the demand in limited time and with multi-dimensional objectives. The results indicated that out of the 40 women went through the check up had problem of leucorrhea. The PAP smear result of the 13 women indicated 70% had severe to acute inflammation, 20% had mild dysplasia.

To understand the problem of anaemia facilities for its estimate was also provided. The results of the blood hemoglobin indicated that 94% women were anemic. 7 women out of 119 had Hb less than 6gm%.

The experience of this activity provided the insight of the need for such health check up and demonstrated the keenness of the women to have such facility.

## **WOMAN'S HEALTH AWARENESS AND DIAGNOSTIC CAMP**

CHETNA has been involved in Water related health awareness campaigns in 99 villages in three blocks of Banaskantha District. At the end of 2 years efforts in this direction, the village women demanded



for information on Gynaecological illnesses which was covered through an educational class. The women further requested organisation of facilities for Gynaecological check-up. Since CHETNA had a positive experience in the past of Gynaecological check-up at the Health Mela therefore, it was felt worthwhile to take up the challenge of organising a gynaecological diagnostic camp to meet the felt need of village women.

A camp was organised on 12th March 1992 on demand for women from 44 villages of Santalpur and Varahi blocks of Banaskantha District. It was a joint effort of CHETNA who took up the major responsibility of organising the camp, the Civil Hospital Ahmedabad who provided the team of doctors, to conduct the check-up, the local NGO Bhansali Trust provided the infrastructure of Anganwadi workers and local PHC provided the venue.

## **PRE-PREPARATION**

The Anganwadi workers of the existing ICDS programme were given the responsibility of collecting the information of women's gynaecological complaints and to assess the willingness of women to go through the clinical check-up. The preliminary information that was collected, indicated that there was a major problem of vaginal inflammation and 150 women showed a willingness to go through the check-up. This actual number increased to 312 on the day of camp.

The one day camp covered following activities.

1. An exhibition on women's health concerns.
2. Small group discussion to establish the fact that women's health was dependent on social, cultural and religious aspects.
3. Collection of information on women's health seeking behaviour related to her gynaecological illness.
4. Clinical check-up / counselling/ treatment

The women went through these activities chronologically.

The group discussion was the first activity carried out at the camp which helped women to understand the linkages of their health problems to their socio-cultural status. The exhibition helped them to be prepared for a clinical check-up.

Information related to health seeking behaviour was also collected through group discussion which indicated that majority of women discussed about their gynaecological problem with their husband as he is a decision maker for the treatment. This indicates the need to involve the men in a women's health programme.



After the discussion, the women went through the clinical check-up. After the check up individually they were provided information and counselling about the disease, and how to prevent it was also explained. At the end they were provided the necessary drugs for treatment.

## **RESULTS**

The results of the clinical check-up indicated that out of 218 women who could be examined major gynaecological problems reported were vaginal infection, infertility and menstrual disorders. 42% had vaginal infection manifesting the problem of white discharge. About 18% had the problem of infertility and 13% had menstrual disorders. Out of the 91 samples collected for the PAP smear 27% were found normal. 70% showed signs of mild to severe inflammation.

## **FOLLOW UP**

Unfortunately intensive follow-up could not be done due to administrative constraints and sharing of responsibility among the involved organisations. One effort that has been done, is that the copy of the case papers have been provided to the PHC and Bhansali Trust who can assist the woman who comes to them for follow-up.

## **LESSONS LEARNT**

Our observation highlights, an urgent need for organising such camps at the community level. However the need for such activities which is already existing at the community level needs to be recognized and provided with the opportunity at right time.

Going through the experience of both the camps, the availability of women gynaecologist for clinical examination and the felt and explicit need of women to have the facilities of gynaecological check-up are the pre-requisites.

We feel that the camp approach with preliminary motivational efforts can provide the perfect setting to attract women at one place for addressing women's health concerns which could either be gynaecological check-up, or health education or any other issues.

Such camps should be in combination with the component of education and counselling which help the women to understand their own health problem and reduce the normal fear of check-up.



Analyzing the experience of both the camps, we feel that there were time constraints in meeting of objectives and number of participants. In both the camps, the number of women who agreed to undergo the gynaecological check-up was much more than our expectation. The diagnostic camp could have been organised for a smaller cluster of villages rather than the large number of 44 villages.

Secondly, CHETNA could have shared the responsibility of organising the camp with local PHC and NGO which would have ensured the follow up activities more effectively. In pre-planning efforts, the history of women could have been taken prior to camp to plan the check-up properly. Especially we felt that in such kind of camp it was difficult to address the concern of infertility. In our camp 18% women had infertility problems which we could not address at the camp level.

## **REPLICATION OF THE CAMP CAMP APPROACH**

The camp approach can be replicated for different themes. For e.g. the existing family planning camp which are mainly organised for target achievement, can be adopted for addressing women's health concerns including gynaecological problems, adoption of family planning methods spacing methods, sterilization and follow-up of spacing methods adopted by women.

We strongly suggest that such a camp should not be conducted merely for examination, it should be ideally combined with relevant health education and counselling to reduce the fear, and clarify misconceptions. Also systematic follow-up strategy should be organised. The follow-up can be done at PHC level as well as at the forthcoming camp about which the information should be provided to women during the present camp.

## **TRAINING**

During the Health Mela, the women health workers strongly suggested that the para medical staff of Government should be trained for addressing gynaecological problems. The need to be equipped for diagnosis of common gynaecological infections which will help them to guide the women for proper treatment and prevention.

The Diagnostic Camps can become effective platform to provide the technical training to the ANMs on the gynaecological health. The TBA, AWW and other grass-root level worker can be utilized as educators and motivators at village level, to enhance the participation of village women in ensure activities.



# INTRODUCTORY PAPER ON CHILD TO CHILD APPROACH

*Minaxi Shukla*

## INTRODUCTION

The Child-to-Child approach is an activity-based approach to teaching-learning. This approach focuses on children being actively involved in taking life relevant education. It is an approach of, for and by the children. The crux of this approach is, that the message grasped by children is translated into action which helps themselves, their families and the community on the whole. Moreover, children gain self confidence and feel enthusiastic about their responsible role. It also improves their communication and problem - solving abilities.

## LOOKING BACK

The Child-to-Child has its roots in the two important events that took place at the end of the 1970's. The first was the 1978 World Health Conference at Alma Ata where the international health community adopted the slogan 'Health for all by the year 2000'. The second was that 1979 was declared as 'The year of the child' at Alma Ata. This focused the attention on health education issue and provided the challenge to professionals working in this field. It was around this time that the Child-to-Child approach to health education was formed.

## EXTENT OF ACCEPTANCE

At present, the Child-to-Child approach has been accepted and implemented by 70 countries of the world. The flexibility offered by this approach to learning makes it widely popular irrespective of class, caste, race, nationality, educational and cultural diversities.

## RATIONALE

Sound health is very important aspect of good living for all human being. And, health is every ones' concern, not just of doctors and health workers. The poignant fact that nearly quarter million children die every week of easily preventable diseases and malnutrition, suggests that much is to be done in the field of health education. As good health is based upon sound knowledge about health care; prevention, symptoms and cure of diseases, we need to understand them. The health

---

*Minaxi Shukla, Chetna, Lilavatiben Lalbhai's Bungalow, Civil Camp Road, Shahi Baug, Ahmedabad-380004.*



education process should start as early as possible because children share as much responsibility as adults to keep themselves and others healthy. Also, every child has the right to learn, enjoy and play at his/her own pace. Taking insight from these and the fact that children have natural tendency of being curious and innovative, a strategy to use these virtues was formed as Child-to-Child approach to health education. The energetic and enthusiastic nature of children makes them ready implementors of whatever knowledge they have received. Also, they act as carriers of the message they have learned.

## **PREMISE**

Taking the gist from the 'Rationale', we can form a premise for the Child-to-Child approach.

**UNDERSTANDING CHILDREN'S POTENTIAL AN ASSUMPTION IS MADE THAT THEY CAN ACT AS CHANGE AGENTS IN THE COMMUNITY BY TAKING THE MESSAGE ON HEALTH EDUCATION TO THE FAMILY AND THE COMMUNITY.**

## **INDIAN CONTEXT**

The Child-to-Child approach has been adopted by India after identifying the health care needs of the people living in both the urban and the rural set ups. The fact that in a majority of the cases both the parents are out of the house for earning their living, poses a question of neglecting the health needs of children at home. There are chances of retardation of growth and development of the children due to lack of care and attention. Also, the daily chores of eating, playing and cleaning the children are taken care of by their elder brothers or sisters. These surrogate parents lack knowledge, skills and experience to take care of themselves and the younger siblings. To equip these children with necessary knowledge about sound health, attempts were being made by individuals and institutions to adopt the Child-to-Child approach. It was around the same time that Aga Khan Foundation India (AKFI) decided to support these efforts and give a big push to the Child-to-Child approach in the field of health education in India. A workshop was hosted by CHETNA to determine the extent of interest in this topic among non-government and government groups. Identifying the same, the initial work began in 3 specific geographical location i.e. Gujarat, Bombay and Delhi. Gradually it has gained the acceptance of many agencies in various states of India.



## **ASSUMPTIONS**

The Child-to-Child approach is based upon certain assumptions.

1. Education becomes more effective if it is linked closely to the things that matter in the day to day life e.g. practical ways to healthy living for children, their families and their communities.
2. Learning in school should be relevant to the child's life outside school e.g. knowledge on personal hygiene.
3. Children have the necessary will, skill and motivation to help and educate each other and they should be trusted to do that e.g. check the nails of children around them.
4. The Child-to-Child approach should be implemented with the local needs in mind e.g. if malaria is a fatal disease in a particular area, prevention and cure of malaria should form the main part of the campaign.
5. The Child-to-Child approach requires vigorous follows-ups for optimum benefits. The approach deals with habit formation of sound health practices and hence the consequences at each stage of implementation should be evaluated.

## **FUNCTIONING OF THE APPROACH.**

The Child-to-Child approach involves children in the task of spread of health messages in different ways. These ways help us to understand how children can effectively act as a medium to spread the health messages.

Activity - sheet is the resource material for the facilitator working in the programme. It includes the theme or the objective of the sheet, the content of the topic on the sheet is for the facilitator's knowledge on the subject, followed by the activities to be conducted with children in order to impart the knowledge. The last section would include the suggested follow-up measures for the facilitator. The sheet although is just a guideline to the topic.

Knowledge reaches the children through these sheets and

1. Children learn to take care of themselves.
2. Children learn to take care of their younger brothers and sisters and other young children staying in their vicinity.
3. They spread the health messages to other children in the same age group who don't attend school.



4. Through interaction with parents the messages are gradually accepted by the families.
5. By working in group activities the children spread the messages in the whole community.

## **CHANGING TRENDS**

Any concept or a programme has to be dynamic to suit the needs of the 'present'. On going evaluation about the programme lend the required innovation. The Child-to-Child approach is no exception. Over a period of time the same has undergone a lot of changes, for the better. Now it is taking the shape of a comprehensive exercise. To mention a few of the most significant changes, the first is that what was launched as a concept is used more as an approach. Developmental issues are tackled by using this approach. A systematic plan of action is made with the principles of Child-to-Child in mind.

Secondly, there is a shift of focus from health education to education of healthy children, child stimulation and sound mental and physical health of the child. What started as sibling care exercise has now been recognised as 'Child Empowerment' exercise.

Thirdly, apart from health, more areas of development have started using this approach e.g. a lot of work has been done in the field of mathematics education and language development by using the Child-to-Child approach. So, Child-to-Child approach has to its credit wide application.

Fourthly, if one wants to give a push to the on-going developmental activities in a particular locality, the Child-to-Child approach becomes more fruitful if health education activities are already been done with adults in the particular locality e.g. HABK (Health Awareness in Banaskantha) project, of CHETNA is a project aiming to bring about awareness regarding safe drinking water, maintenance of water-post and water borne diseases. The focus group of the project is the rural women. To supplement this project, it was decided to work with children of the area. A Bal-mela (Children's fair) was organised in the area on importance of clean water and sanitation. The organisers could clearly make out that the Bal-mela was more successful in this district in comparison with the same organised in the other district of the area.

## **CHILD-TO-CHILD FOR PRE-SCHOOL**

Though the Child-to-Child approach was primarily designed with the primary school children in mind, it is now used for pre-school as



well. In India, formal or informal schooling starts at an early age of 3 years. Though formal pre-school education is more of an urban phenomenon, the anganwadis and the balwadis take care of children in rural areas. Also, there is a great amount of diversity among the urban and the rural centres. But, there is not much difference among the children living there. As the Child-to-Child approach harnesses the potent natural characteristics of the children, the approach can be well accepted for pre-school children in the whole of India.

The main advantage for applying this approach for the pre-school level children is that this approach deals more with habit formation and it is necessary to start it as early as possible. If a pre-school child is trained from the very beginning, he/she has a distinct advantage over the primary school child who gets the same training.

Some of the observations regarding the adoption of this approach at the pre-school level are mentioned here.

1. Though the pre-school children may not be able to effectively communicate the message, they interact very effectively with children of their age.

2. Though a 3 year old child cannot be expected to take care of his/her younger siblings, a 6 year old child can do that very well. And if both have the experience of the Child-to-Child approach, the compatibility in functioning improves to a great extent.

3. A pre-school child acts more as a doer and less as a messenger. He/she needs support systems to practise what has been grasped from the health messages. This means that the environment in which the child lives should be cordial for effective implementation of this approach.

4. Though a pre-school child may not be very efficient medium in the individual capacity, collectively a group of pre-school children can work wonders. So, maximum stress should be laid on group work.

## **PRACTICAL GUIDELINES**

The Child-to-Child approach is a way of teaching-learning about health which encourages children to participate actively in the process of learning. It deals with creating an atmosphere where children get motivated to put into practice what they have learned. For this purpose one must keep in mind:

1. The subject, content and complexity of health information depends on the age and developmental level of the children.



2. The activity orientedness of the programme provides a 'Cafeteria approach' of teaching to the children. It gives them choices in learning at an appropriate pace. It is ultimately the child who decides what to accept and what not to.

3. Activity sheets are a resource material for those who want to start Child-to-Child approach. They can be used by teachers, health and community workers. They are designed by keeping in mind the age, interest, understanding and experiences of the children. The activity sheets contains text and illustration. They can be modified to suit the local needs. Each activity sheet is divided into several sections.

- \* A clear statement of the main idea or objective
- \* Detailed information about the subject
- \* A wide selection of suggested activity
- \* Separate section on follow-up

4. Child-to-Child is a human approach. It continuously needs change and modifications with the change in the environment. It can be used very effectively to change tomorrow's society, provided the facilitator is continuously on vigil.

## **TO END**

The Child-to-Child approach can be very effectively used for the campaign education for All, by 2000 A.D. The children of today can be effective change agents for a better (Healthy !) tomorrow.



# **NEED OF THE DAY**

## **“SEX EDUCATION TO ADOLESCENTS”**

*Ms. Anuja Kak*

### **NEED**

CHETNA has been working with adolescent girls since 1990. Based on our experiences there is a need to develop need based field tested educational material which would address scientific facts to counter social beliefs and myths related to “SEX” among the rural adolescents of Gujarat and Rajasthan States of India.

The educational material thus developed can be used by the health functionaries and development workers to raise awareness and impart education to adolescents and their parents.

### **INFORMATION COLLECTION**

With this aim in view, the first step was to conduct a knowledge, attitude, Practice study of 5 villages of Kheda and Bharuch districts of Gujarat State. CHETNA in collaboration with some field based NGOs like “Tribuwandas Foundation” at Anand and “Vikas” at Jumbusar could get an infrastructure of 5 villages namely Rajpura, Bhungaliia, Limdi of Kheda District, Malpur and Jamdi of Bharuch District. About 68 men and 50 women between the age group of 13-40 years of age were interviewed. Discussions and graphic workshops were also facilitated in each village to determine the understanding and visual vocabulary of village community. This would further help in the analysis of information and in presenting the messages in visual form.

### **ANALYSIS**

The informations collected from the villages were of varied interest and topics, although there was a structured questionnaire with us. These informations were then analyzed, classified and tabulated at the organization level. The analysis of these informations determined the broader sources of these beliefs and myths and areas of emphasis. The decisions on form of presentation of messages were also determined. All these decisions and many other were taken by

---

*Ms. Anuja Kak, Chetna, Lilavatiben Labhai's bungalow, Civil Camp Road, Shahi Baug, Ahmedabad-380004.*



consulting professionals and individuals. The significance and relevance of these informations was also clarified and understood to know the basic source of these beliefs and myths and truth behind them.

### **Beliefs and myths like**

- \* "Menstruation means loss of Virginity"
- \* "Females are created impure by God", so all menstruating women are impure.
- \* The one who bears the child must bear the impurity-this is the basic difference between man and women.
- \* To prevent misled activities like love affairs, marriages to be performed at an age of 10 years.
- \* Masturbation leads to fall on physique, over doing leads to weakness, and to dilution of seminal discharge and hence affects the man's ability to pro-create adversely.
- \* over doing (masturbation) leads to infertility.
- \* Masturbation is a sin.
- \* Pregnancy is like a lotus, when semen fall on a bloomed up lotus, a few days after, the lotus closes and the mystical process of creation of life begins.
- \* When tiny creatures in men meet tiny creatures in women pregnancy occurs.
- \* Girl child is born because of short coming in women.
- \* Pre-marital sex and un-wed mothers are not accepted by the society. Abortions were carried out frequently.
- \* People believe that Nirodh (Condom) is used for masturbation
- \* Sexually transmitted diseases occur due to too much of sex.
- \* Tuberculosis occurs due to too much indulging in sex.



## **FOCUS**

Keeping in mind the areas to be emphasized it was thought proper to focus on the social and technical part of the topic like adolescent development, menstruation, marriage age, abortion and pregnancy. It was thought that these areas of emphasis should focus more on the social aspects rather than on technical aspects which can be taken care of by the "CHILD BIRTH PICTURE BOOK", which is developed in several Indian languages by CHETNA and which can be a part of the kit on " Sex Education" to be developed by CHETNA in future.

After discussions with some of the individuals and professional it was found that the best form to address the social beliefs and myths would be to develop short stories and songs, which would be interesting to narrate, to hear, follow and to remain in the mind for a longer time in the growing/developing minds of the adolescent boys and girls.

## **ACTION**

The short stories on the area of emphasis were prepared and the illustrations were designed. The illustrations were decided keeping in mind the age and creativity so as the material would provide enough understandability. The stories were divided into sub-parts and for each part one illustration was prepared. These would finally be printed in Book or Flash card form. The language of material would be English, Hindi and Gujarati.

## **FIELD TESTING**

After the stories and illustrations are ready in the form of Book a Flash Card, these would be field tested in more than 5 villages and a larger number of men and women would be approached/reached to determine clarity and understandability of content and illustration. After this is done, the stories would be finalized according to the field level and organization level feedback on each and every story and song.

The final printing, layout and design would be decided keeping the printing cost in mind. Mass distribution of this material would be done to individuals and organization for appropriate use.



## **Section IV**

---







# INVOLVEMENT OF PEOPLE IN A LONGITUDINAL RESEARCH PROGRAM DEALING WITH HUMAN REPRODUCTION AND GROWTH

*Dr. P.S.S. Sundar Rao*

Most developing countries are characterised by a high infant mortality and a relatively high fertility. Both are not amenable for reduction solely through direct medical intervention, but require increasing social support, political will and developmental changes. High infant mortality is largely due to low birth weight and pre-term deliveries and it is important to study the correlates of birth weight and gestation (Intra Uterine Growth Rate) in order to reduce them through rational programs for mother and child. Family formation and up bringing of children relies heavily on socio-cultural aspects. Many health program have failed to take this into account and the top-down approach requires replacement by peoples involvement at all levels. Initiatives such as child survival and safe motherhood (CSSM) or developmental programs for the girl-child cannot succeed without the full cooperation and participation of the people concerned. Such involvement should begin even at the stage of planning research data collection and continue through out the various stages of research.

The Vellore longitudinal community study was launched in 1969 to observe various aspects of human reproduction in representative and random samples of rural and urban women. The objectives included the intrauterine growth as well as other events that have a bearing on outcomes of pregnancy and infant survival. A prospective study was deemed necessary in view of the fact that such data as are available through service statistics are unreliable or not even existent. Ascertaining personal information from the community such as menstrual status, inception of pregnancy and measuring newborn and children requires tremendous public cooperation and understanding of the issues involved. In the process of building up rapport, the community also gets enlightened and educated which in turn has other benefits apart from increasing the accuracy of the variables measured. In many instances, the accuracy of the variables measured. In many instances, the research process itself gets refined through ideas from the community themselves.

---

*Dr. P.S.S Sundar Rao*

*Professor and Head, Department of Biostatistics, Christian Medical College, Vellore 632 002. India*



Another problem in several research studies relates to assessment, especially of a quantitative nature, which encounters resistance from certain groups in the community due to superstitious beliefs and value systems. For example, it is believed that repeated weighing can lead to weight loss, that reporting of accurate age leads to premature death or that measuring length is associated with making coffins and is thus inauspicious etc. These objections must be overcome with great sympathy and diplomacy.

I shall now present some of these aspects based on our experiences in the organization and implementation of the Vellore Longitudinal Studies. These studies were done in North Arcot District choosing representative and random segments of Vellore town to provide an urban sample of about 40,000 persons and geographic segments from a nearby community development block to provide a rural sample of about 50,000 persons. First of all, the leaders in the community chosen were approached and the research issues discussed. Subsequently a variety of group meetings and focus group discussions were held with representative members in the community, and the adult family members. The objectives and scope of this research were explained and their opinions and strategies discussed.

The field personnel for this project were all women, chosen from the community themselves and given necessary training and orientation to the research project. Each investigator was given a manageable area to cover the sample of women in the reproductive ages and their children visiting once in five weeks, to obtain data on menstrual status, specific health events, pregnancy status and terminations, maternal morbidity and other relevant informations. Local informants were chosen to assist in identification of selected vital events. For every 4-5 such investigators, a social scientist (woman) was appointed as Field Supervisor. For purposes of liaison and contacting leaders, a senior male coordinator was appointed.

Each liveborn was visited within 48 hours of birth for birth measurements and observations. Details of labour, child birth and immediate puerperium were also ascertained in this visit. Every liveborn was visited monthly during infancy, 6 monthly during preschool years and yearly thereafter for observations and measurements on growth and development. Five percent of all women visits, pregnancy terminations and child-visits were re investigated by supervisory personnel for validation and quality control. Periodical review meetings were held not



only with the staff but also with community leaders and groups of families involved. Results of the analysis were shared with the community and further ideas and suggestions for improving research obtained.

During the 4 year period of this research from 1970 - 73, a total of 14000 pregnancies were identified, of which about 10000 resulted in single live born. Half of them had both gestation and birth weight accurately determined. Initially the scope of the Vellore longitudinal Studies was restricted only to infancy, but subsequently the infants were followed up through their pre school and later school years to the extent possible. At present these children have just completed their adolescent period and are establishing their own families. Thus the present research thrust is to determine inter-generational changes in various aspects of human reproduction and growth that have a bearing on the quality of life of our children.

It is emphasized that such studies cannot provide authentic data without establishing proper rapport and the full cooperation of the entire community, even though the data may pertain to a specified individual, such as the child or the mother. The entire family and the leadership should be consulted and their active assistance sought at every stage. Provision of medical services as an incentive per se need not necessarily bring about good cooperation. In fact no such services were provided, in this study, except friendship and partnership, which resulted in successful data collection. This underscores the great value of involving the people in a participatory manner even in research which is generally considered the prerogative of experts. No community research will be successful without such involvement of the people themselves especially in longitudinal studies which have a great potential in providing data for rational health planning and programme implementation.

In summary, it is our personal experience that community health research which is needed for community diagnosis and management must be participatory; the data collectors must be locally chosen through community involvement and the monitoring and quality control must be ensured through various participatory processes. Research should be truly community based and not just community-oriented. The findings can then be more easily applied to formulation of effective health programmes.



# PARTICIPATORY APPROACH IN POPULATION HEALTH SURVEYS

## -A 10 YEAR EXPERIENCE IN LYMPHATIC FILARIASIS

*Drs. Sakthivel Maruthamuthu  
Aravindan M. Theodore  
Ambalavanar Iyanar  
Abraham Joseph*

### INTRODUCTION

Epidemiological surveys are conducted from time to time to study the magnitude of the problem of Lymphatic Filariasis. Non-response and resistance from the community, however have hindered the conduct of these surveys, very often resulting in difficulties to arrive at a realistic and accurate assessment of the disease profile. The same factors have also been responsible for the non-compliance to treatment by a symptomatic microfilarial carriers.

In a 10 year study organised by the Community Health and Development programme (CHAD), Christian Medical College, Vellore in two rural community blocks, the problems of non response and non-compliance to treatment were minimised by adopting the community participatory approach.

This paper highlights the salient features of this approach to ensure effective community participation.

### THE PARTICIPATORY APPROACH

In Primary Health Care recognition is given to the fact that people are able to think and act constructively in identifying and solving their own problems. Placing faith in the innate ability of the people in managing their own problems, the educational inputs in this study were planned so as to:

- a. promote maximum community and individual self-reliance.

---

*Sakthivel Maruthamuthu, Health Officer  
Ambalavanar Iyanar, Health Officer  
Aravindan M. Theodore, Senior Lecturer (Entomology)  
Abraham Joseph, Professor & Head,  
Community Health Department, Christians Medical College,  
Vellore - 632 002, S.India.*



- b. Provide people the opportunity to participate in the planning, organisation and conduct of surveys.
- c. supply them with necessary information to help them to develop skills and build up confidence in communication.
- d. entrust people with the responsibility of carrying out preventive/control measures.

This method aims at making the survey a people's programme, with people participating in every stage of the programme, from planning to execution, as could be discerned from the following description of the various steps.

## **STEP I**

### **MEETING WITH THE LEADERS**

As real change comes from within the village and from the people living in the village, working with the leaders was considered very important for the success of the survey. The very first step undertaken was to meet the leaders of various caste groups and of different age groups.

The meetings had the following purposes :

1. To create an awareness of the problem, methods of spread, early diagnosis and treatment and disease prevention/control alternatives, in order that the leaders would serve as communicators to the entire community.
2. To elicit information about the local beliefs and practices that can be incorporated in the educational package.
3. To plan the details of the survey, ensuring community participation during the various stages of the study/survey.

A schedule of activities to be carried out is presented in Table I.

## **STEP II**

### **MASS EDUCATION IN THE COMMUNITY**

To sensitise people about the proposed survey and to provide information about the disease, atleast one mass education programme, usually a film show, was organised in each of the villages. In some villages, this was supplemented by staging a skit, by training the local school children.



### **STEP III**

#### **GROUP EDUCATION**

For maximizing the coverage discussions were held with several organised groups like school children, women, youth clubs, learners in the Adult and Non-formal Education Centres and workers in the craft centres. In places where such organised groups were non-existent, special efforts were made to group them.

Issues specific to each group were taken up for discussion in these meetings (Vide Table II.)

Volunteers from various groups were enlisted to help the survey team in all its activities.

### **STEP IV**

#### **SOCIO CLINICAL SURVEY**

The survey team undertook the responsibility of preparing the sampling frame. The names of the persons to be surveyed for the socio-economic assessment and night blood collection were listed and provided to the volunteers using appropriate sampling method. Volunteers served as effective communicators in giving messages about the disease and the night blood survey, during informal discussions with family members at the time of the survey.

As addressing any one of the perceived health needs of the community is a necessary pre-requisite, a conscious effort was made to comply with this golden rule, by giving suitable counselling and health advice to the problems presented by families, during contacts for socio-clinical surveys and thereafter.

#### **NIGHT BLOOD SURVEY**

The night blood survey was carried out between 10.00pm and 2.00am. While some members of the survey team collected blood from the inmates of households, the other members helped to reinforce the knowledge provided earlier. The presence of a leader of the village in the survey team facilitated the smooth conduct of the survey.

#### **ABSENTEE FOLLOW-UP SURVEY**

An absentee follow-up survey was done the following day. Here again, it is the volunteers who made special efforts to motivate the absentees to remain at the time of the survey.



## **STEP V**

### **SHARING SURVEY FINDINGS AND PLANNING INTERVENTION**

At the conclusion of screening of blood smears and analysis of results, a second meeting with the leaders was arranged to brief them about the findings of the survey and to discuss about possible community measures against the vectors and preventive measures against reinfection. As filariasis is still considered a social stigma of sorts, the identification of M.F. carriers was withheld, in compliance with the request of the leaders.

## **STEP VI**

### **FOLLOW - UP SERVICES**

To maintain the rapport with the community, follow-up action is necessary. The list of affected persons (M.F. carriers) was given to the village-level workers, who undertook the responsibility of motivating them to attend the mobile clinic or PHC to collect the drugs. The village-level workers were also given the responsibility of motivating persons who had hydrocele to go for surgical remedies at referral hospitals.

In all villages, follow-up education on control of mosquito breeding was done by the field staff and in many villages community action was ensured. Year-round culicine breeding activity in many villages is concentrated in three different places - cess pools, cess-pits (covered and uncovered) and blocked drains. The following source-specific vector control measures were undertaken by the community under the guidance of the CHAD staff;

1. Clearing of blocks in drains.
2. Single or double soakage pits in the place of cess-pools, where feasible and in other places periodic treatment with oil or detergent powder.
3. Treatment with oil in cess-pits (open).
4. Restoring the lid or stone slabs firmly on the cess-pits, leaving no crevices or openings to ensure termination of egg-laying by mosquitoes.

## **DISCUSSION**

Of the 168 villages in Kaniambadi and Anaicut blocks of N.A.A.DT., Tamilnadu, with a total population of nearly 2,15,000, forty villages with an approximate population of 60,000 were covered in the study during different seasons of the year. The response rate was more than 80% in all villages.



Such an encouraging outcome is mainly attributable to the approach that was adopted for the conduct of surveys. The participatory approach envisages that people be made responsible for their own programmes. In this study, it would be observed that representatives of the community were given the opportunity to participate practically in all the stages of the programme. Representatives of the people were also given the responsibility to educate the other members of the community, were given the opportunity to participate practically in all the stages of the programme. Representatives of the people were also given the responsibility to educate the other members of the community during the various stages of the programme by placing confidence in their ability to participate in the education process. When leaders and members of their own community were involved in the communication process, people had the satisfaction of listening to messages from their own kind.

Education was not limited to a single method or session. It was multi-pronged approach. Mass education programmes, small group meetings and individual contacts had their share in making people participate in the programme. Different educational aids like flashcards, model and flip charts were also used. Specific messages for different groups helped in sustaining the interest of the members of various groups.

Based on the experiences of the authors in carrying out population surveys, the following steps are recommended as important strategies for successful community participation:

1. Planning, Organisation and conduct of the survey should be done with the active participation of the community.
2. Preparation of the various approaches to empowerment and criteria for motivation should be based on the existing levels of knowledge of the disease among the different segments of the society and should appeal to the specific interests of various groups.
3. Extensive use of Audio-Visual aids/folk-lore helps in preparing the community for the survey, and in improving their knowledge.
4. Involving various groups in the village such as the school children, for staging processions/skits will help in achieving publicity and awareness for the programme.
5. Inclusion of volunteers from all available groups helps to overcome possible resistance particularly during night blood collection.



6. An earnest effort must be made to address some of their felt health needs. This will help in winning the confidence of the community.
7. The presence of a lady member in the survey team helps to obtain a true picture of the clinical disease and its manifestations in women.
8. As Filariasis is still considered an unfortunate social stigma in some rural communities, a conscious effort should be made to keep the list of M.F. carriers confidential.
9. In villages where organised groups of men and women are not available, special efforts can be made to form such groups, for the purpose of the survey.
10. At the end of the survey, atleast one intervention method-environment friendly - to the extent possible should be demonstrated to the village community. Example - Construction of a soakage pits.

**TABLE I**  
**WORK SCHEDULE \***

STEPS	DAYS	ACTIVITIES
1.	1 <sup>ST</sup> DAY	Leaders meeting
2.	2 <sup>ND</sup> DAY	Mass Education Programme in the community to create awareness
3.	3 <sup>RD</sup> 4 <sup>TH</sup>	Group Education and Identification of Vector - Breeding Sources:- 1. Youth 2. women 3. Adult and Non-Formal Education centres. 4. Handicraft centres. 5. Schools 6. Farmers' Forum
7. Others.		
4.	5 <sup>TH</sup> & 6 <sup>TH</sup> DAY	1. Socio-Clinical surveys - 5.00 pm to 9.30pm. 2. Night-Blood Collection -10.00 pm to 2.00am.
5.	7 <sup>TH</sup> DAY	Absentee follow-up survey.
6.	8 <sup>TH</sup> DAY	1. Screening of Slides
	9 <sup>TH</sup> DAY	2. Compilation of data
7.	10 <sup>TH</sup> DAY	Second leaders' meeting for - 1. Presentation of results of the survey. 2. Discussion of preventive measures against the reinfection of vectors.

\* Depending upon the size of the sample involved, this work schedule can be shortened or extended.



**TABLE II**  
**GROUP-SPECIFIC MESSAGES**

**A FOR LEADERS :**

SPECIFIC MESSAGES	METHODS & AIDS	DESIRED RESULTS
1. Health consequences of untreated disease carriers as they affect the village community 2. Broad understanding of filariasis as a public health problem in the national context	1. Individual contacts 2. Group discussions	1. voluntary participation in the planning, organisation and conduct of surveys. 2. Selection of volunteers to accompany the survey teams. 3. To positively influence the community to help attain maximum coverage. 4. To initiate prompt community action in undertaking vector/parasite control measures along with members of the survey team.

**B FOR WOMEN**

1. Importance of subjecting children for clinical examination 2. Loss of marriage prospects involving girls in the marriageable age group. 3. Ravages of the disease as such and disfiguration of the extremities.	1. Group discussion with the use of flash cards. 2. Discussions in the light of specific instances of stopped marriages and broken family relationship.	1. Voluntary participation during surveys 2. To accept kitchen garden as a means of discouraging mosquito breeding around sites of accumulation. 3. To destroy unused pots, tins and animal feeding troughs,
--	--	--



---

## FOR THE YOUTH

---

Specific Messages	Methods and Aids	Desired results
1. Manifestation of disease in full form as affecting career prospects.	1. Demonstration of wax models as affecting extremities. Breast and genitalia.	1. voluntary participation during survey in accompanying survey teams, particularly during nights.
* EXAMPLE: Loss of recruitment prospects in the armed forces.	2. Specific instances of rejection on grounds of hydrocele during recruitment for the armed forces.	2. Offering manual services, when community action is contemplated  EXAMPLE: Construction of soakage pits in the community.

---

## FOR SCHOOL CHILDREN :

---

1. Some common place knowledge relating to the etiology of the disease and possible preventive measures.	1. Class-room lectures with charts, with special reference to life-history of the parasite and the vector.	1. Publicity about the survey.  2. conduct of processions prior to the surveys and vector control activities  3. participation in Skit
--	--	--

---

\* Kaniyambadi and Anaicut blocks of North Arcot Ambedkar District have been contributing a sizeable number of soldiers to the Armed forces.



## REFERENCES

1. W.H.O. Expert Committee on Filariasis (1976) World Health Organisation Technical Report Series No. 359.
2. Present status of Filariasis problem in India.  
Sharma S.P., Biswas H., Das M., Dwivedi, S.R.,-  
Journal of Communicable Diseases (1983) 15:53-60.
3. Training doctors for primary Health Care:  
The Vellore model Abraham Joseph, world Health Forum,  
volume 6, 1985.
4. Role of Universities and Hiegher Education for Achievement  
of Health Objectives-  
M.E. Yaolekar - The Indian Journal of Medical Education  
volume XXVI No.2.
5. WHO Chronicle 1978.
6. WHO Technical Report Series - 702 -The Primary Health Care  
System and Community participation in the control of Lymphatic  
Filariasis: 1984.



# CAPACITY BUILDING THROUGH PARTICIPATORY TECHNIQUE: AN INNOVATIVE APPROACH FOR EFFECTIVE PARTICIPATION OF WOMEN IN HYGIENE EDUCATION PROGRAMMES

*O.T.Rema Devi*

Peoples participation is now a days a fashionable terminology in all the development programmes. As per records, almost all the programmes are planned/ implemented through 'peoples participation'. If the number of planning meetings, resolutions and visits the area are taken by any means as indicators for development, we should have achieved 200% community development! (group meetings, of course, are the best possible interaction in many instances - provided giving more opportunities on how to think than on what to think). But we all know how far behind we are.

As we are concentrating more on women's participation, let us take a deeper look into that area.

We have a lot of adjectives for women as 'vulnerable' 'target groups' 'reserved' 'special category' and so on in all the developments schemes. In a major part of the health education programmes of the Government and International agencies, the target groups are women and children and the approach is imposing whatever we wanted to convey - whether those who recieved like it or not - in an effort to please our planners and evaluators. We, in this haste, conveniently forget that this 'messages approach' only touches the surface of the problem. There is a wide gap between what these women wanted and are lacking and what we wanted to give them.

In a KAP study done by our Project in the three Northern Districts of Kerala, it was found that majority of women had the positive knowledge and Attitude towards health behaviours, but ironically, when it came to positive practice, it was nearly zero.

---

*O.T Rema Devi, Programme Officer  
Socio-Economic Unit (N) (DANIDA)  
Kerala Water Authority, Calicut-9*



Our women are not ignorant. They may be literate or illiterate. But they have the normal Intelligence Quotient. Due to some bad luck or lack of opportunities, their faculties did not develop. They are very good decision makers in families where they are given opportunities. We utilise and develop this capacity. They have proved their abilities where chances were given. Then why don't we utilise this in the hygiene education programmes or in the development programmes. Why don't we take an effort to get at the root of their problems and assist them in making decisions to change their own behaviour so that the change that is made is a permanent change rather than an impulsive change out of compulsion which could have a reversion or ill effects. In the participatory Hygiene Education Programme, the content oriented, learner oriented approach is substituted for a message oriented, trainer oriented approach. Other points of significance are,

1. Individuals and their creativity and their special group situation advantages are given top priority.
2. Ability to form opinions and take rational actions and their resourcefulness are encouraged and developed.
3. Development of oneself and one's surroundings are facilitated.
4. The entire programme is featured by flexibility and responsiveness.
5. Awareness of opportunities and options are increased.

In nutshell, the two important faculties of intelligence viz., thinking and reasoning are given proper attention. So the programme is geared to one of developing a thinking mind, and thus developing a positive attitude through proper action towards better health and better standard of living through deductive thinking.

This innovative approach that was tried out in a very socially and economically weaker panchayat called 'Munderi Panchayat' of Kannur District, Kerala had a very modest beginning but a heavy behind the curtain preparations. A group of ICDS workers were trained in this new approach and two volunteers undertook the task of using this approach in their mother's meetings. Socio-economic Unit staff also assisted them in the initial stages and in order to make the sessions stimulating the teenaged sisters of the anganwadi children were also invited thus having a total strength of 20-25 women. We assembled under a tree in a circle. The ICDS worker having briefed them earlier about the participatory approach, asked them to form three sub groups and to



choose one volunteer for each group. The session started with creative mapping exercise centered around the anganwadi with, other institutions and amenities they know. In this creative session, participants used locally available materials like charcoal, sand, dried leaves, stems of trees, sketch pens (These mothers' never had a chance to hold a sketch pens in their life time) etc to make the maps more attractive. The maps were drawn in chart paper provided by the unit. After the exercise, the group leaders presented the activity they had prepared. The groups' enjoyment, relaxation and contribution were extremely encouraging. We planned to have a six months programme with one session each month.

The second, third, fourth, fifth and sixth sessions were on personal hygiene, home and food hygiene, environmental hygiene, water hygiene and use of latrine. The tools included exercises like role play, bridging the gap, matching card, two circle exercise, health games, voting exercise, percentage agreement exercise, building the unit etc. In all these sessions, there were effective participation physically and mentally and they enjoyed and wanted to continue the session. Since a particular day of the month was fixed (like every second Thursday evening) the participants were eagerly waiting for the get together, arranging all other household chores - before hand.

Once the six sessions were over, they requested for three more sessions and we had those too. This group, in the concluding session, undertook on themselves the role of voluntary health educators in the locality, motivating their friend and relatives. To quote an old muslim lady "You go and look into kitchen side of these women you will be surprised at the level of cleanliness they maintained after their sessions. You go and look at the nails of the children here. They are cut properly and regularly" and so on. These behavioural changes were the result of their own discussions and exercises. We were there only to arrange and stimulate these exercises.

As this programme proved successful, we extended it to other areas of different panchayats (28 in all) in which we are working for water and sanitation. Topics like kitchen gardening, good nutrition, proper drainage, systematic home management etc. emerged from themselves. They started asking for more economic programmes realising the need for economic self-reliance. In few areas the volunteers took the initiatives to contact the local lady village extension



officer and invited the Districts Women's Welfare Officer to appriase them of the different economic programmes available. They conducted a camp for this purpose and they are now in the process of starting one or two units that would increase their financial capacity too.

(Some samples of their creative need based demands and thoughts are here: Different factors contributing to lack of home hygiene, personal hygiene, sources of water, water contamination possibilities)

The following are some of the points to be kept in mind before embarking on a participatory hygiene education programme:

1. The group must be a familiar one.
2. The group should be a sufficiently informed of the new approach.
3. Participation of all the persons should be ensured.
4. The trainer should be only a facilitator.
5. The facilitator should be sufficiently prepared to meet any contingency like an alternative approach to suit the groups interest. A lot of home work is required before the training session.
6. The exercise given should be simple and action oriented.

Lessons learned and also some points of interest expressed by the group

1. The facilitator becomes a learner in many cases. The special points peculiar to the groups or points which we tend to forget (we might have totally ignored or omitted those points in a class-room situation) are brought out by the group as a whole and those things are discussed and learned with a positive approach to change one's behaviour.
2. The participant becomes refined and reformed because she was also an active partner in the discussion and so a desire to show positive change emerged from within and tried to sustian the interest and behaviour.
3. The group members individually felt important and acted as a catalyst in improving the community as a whole without any external pressure.



4. More and more stimulations took place with the result that they came to know more about the different development programme available and tried to get the benefit of these programmes.
5. An increased level of social harmony developed between the members. House holders who did not talk to each other earlier due to some family disputes forgot their differences and joined hands to work as a group.
6. As the group was divided into three sub groups a healthy competition also existed which acted as a motivating factor among the group to participate more effectively and fruitfully.
7. The overall capacity of women individually and as a group improved as was evident in their later efforts to improve their own homes and also the community.

As result of the positive outcomes of this approach SEG's entire hygiene education programme focus more on participatory approach in the training as well as awareness programme. The Standpost Attendants, the user groups of water and low-cost latrine all are now receiving a different type of education with emphasis on thinking, reasoning, creativity and capacity building rather than receiving just health messages on water and sanitation. We have thousands of user groups for latrine and piped water. Now with this approach, we have started cost recover system from the user of piped water on an experimental basis in one panchayat and it has been proved successful.

Extension of the Approach to different disciplines: The participatory Approach was extended to four groups in different disciplines.

1. The Health Services Department Personnel - the Medical Officers, the JPHN and Health Supervisors, the JHI and Senior Health Inspectors in the scheme areas. The health Service group of Maharashtra through the Tata Institute of Social Sciences were also given training sessions on this approach.
2. The ICDS(The Integrated Child Development Services) : The whole group from Child Development Project Officer to Anganwadi Children worker was trained together.
3. The School Teachers, where our school health clubs are functioning.



4. The Ward Water Committee Members (local group committee volunteers within the panchayat) who are totally involved in their planning, implementing and monitoring of water and sanitation.

The major objective for extending the approach during training of the department personnel was to make them aware of the need for a changed approach to make participation more effective and meaningful. Very often, we found that interest of these groups diminish because of low level of motivation or sometimes even negative attitudes of higher officials in the department.

Let us try to make learning more people oriented and also to make them better persons mentally and physically. Let us not impose on them what we wanted them to know. The beginning may require more efforts and patience but the end is going to be marvellous. Let us not quantify the health education - but work for a need based qualitative education for those who need it.

## REFERENCES

1. Srinivasan Lyra, Tools for community participation. A manual for Training teachers in participatory techniques 1990. PROWWESS/ UNDP.
2. A forward looking assesment of PROWWESS (Promotion of the Role of Women in Water and Environmental Sanitation Services) 1991. Report of an Independant team. UNDP.
3. People, Water and Sanitation. What they know, believe and do in Rural India 1990. The National Drinking Water Mission, Government of India. Filariasis : 1984



# PEOPLE'S INVOLVEMENT IN RESEARCH ON DETERMINANTS OF FEMALE AGE AT MARRIAGE

*J. Richard\* and P.S.S. Sundar Rao\*\**

Most intimate information such as opinions and reasons for certain behaviour and practices are hard to get in an impersonal environment. Participant Observation Techniques, in which, the researcher participates in the life of the community have been used for a long time to research various issues. Recently, the approach is reversed and the methods of involvement of people are initiated to study them or the community. Notable among them are Focus Group Discussion, Rapid Rural Appraisal and participatory Rural Appraisal. These throw more light on the various aspects such as personal attitude, decision - making process and so on. Success depends mainly on the efforts of the researcher to listen to the people on the topic of the research and also the extent of involvement of the people.

People's participation was used in a study to determine the decision-making process leading to the timing of marriage of females and also to explore 'in depth' the forces of change that appear to modify traditional norms regarding timing of marriage. The detailed methodology adopted and the findings are presented in this paper.

The timing of marriage in most developing societies depends on a complex decision -making process of the whole kinship system, and to a large extent dominated by the decision of parents or grandparents. This does not entirely depend on physical and mental maturity of the bride or the groom but rather on the decision of the patriarch to make economic, political and social gains through alliances (Ruzicka, 1977; Dubey and Bardhan, 1978; Caldwell et al 1982). Mc Donald (1981) argued that marriage customs, including norms about age at marriage develop in each culture in relation to the functions that marriage fulfills

---

*J. Richard and P.S.S. Sundar Rao*

*\* Professor*

*\*\* Professor and Head*

*Department of Biostatistics*

*Christian Medical College*

*Vellore - 632 002 INDIA*



in the society. He specified certain economic, social, personal and psychological functions. In short, the timing of marriage is a multidimensional sequence of conscious decisions taken by a set of people, in a complex pattern, well balancing biological, social, economic and political gains and also following the dictates of customs or tradition (Srinivas, 1977; Goyal, 1979).

## **MATERIALS AND METHODS**

The study areas are the Vellore town (urban) and the K.V. Kuppam Block (rural) of the North Arcot Ambedkar district of Tamil Nadu. All villages in our study rural areas were arranged according to the development status and one village in each development state, namely, Low, Intermediate and Fair, was randomly selected for indepth study. Similarly the urban areas were classified into development status and one 'less developed' and one 'more developed' areas were selected for the study. In the selected villages and the urban areas, trained female social scientists were staying for doing indepth study. A list containing name and other identification details of about 75 unmarried girls was prepared for each village or urban area, from the records maintained through the previous studies of the department (Biostatistics). These girls were born between 1969 and 1973 when the department was having a research project which was monitoring all the births that had occurred. So the date of birth of them were accurately known. The list also had the names and identification details of elder siblings of them. These girls were called as target girls and the study was centered on the necessary aspects of marriage of them.

The social scientists visited the houses in which the target girls were staying, discussed about the members of the families and their marriage customs after gaining their confidence. During these visits they never took with them any proforma or notebook or diary. They carefully listened to the conversation between the family members or the discussion with the members regarding various aspects of marriage. As soon as they returned to their residences they wrote all the information obtained from the households in a notebook called work-diary. If there was not enough time to write the diary, they recorded all the information in a cassette using a cassette recorder and later on transcribed to the work-diary. They also organized small groups of family members and relatives to discuss the process of decision-making. During these sessions they identified the key family member and had individual discussion with that person. The content of the discussions were similarly recorded in the work-diary. The information contained in these diaries were analysed to get the findings.



About a dozen 'influential' women and a good number of girls of prepubertal age participated as informants. The study was conducted for about two years and altogether 222 girls from the rural areas and 172 girls from the urban areas were followed up and 48 and 19 girls got married in the rural and urban areas respectively (Table1). The proportion married at the end of the study was higher in the rural than in the urban areas.

## **FINDINGS : DECISION-MAKING**

Persons who were mainly involved in these decision-making process vary (Table 2.) Nearly a quarter of the marriages both in the rural and urban areas, involved only the parents of the groom or bride in the decision-making process. Involvement of siblings of parents and siblings of the groom or bride were noted in another one quarter of the marriages in both the areas. Involvement of the parents (and/or their siblings) and grand parents (and / or grand uncle/aunt) in the decision - making process was found in about one in five of the rural marriages nearly half of the urban marriages. The bride was consulted on the choice of the groom or informed about the groom in most of the cases.

## **FINDINGS : FORCES OF CHANGE**

The main force of change that appear to modify traditional ways in all aspects is the erosion of extended or joint family and the advent of the nuclear family.

Traditionally while selecting a groom the main aspect considered was the kinship relationship. Now the change is towards a person in modern sector of economic activity with good education.

The main process of finding a mate has undergone a change to the extent of delaying marriage. In villages, the traditional system was, the parents of the boy meet the parents of the girl and ask her in marriage for their son. Now it is the other way. After waiting for a few years, the girl's parents have to go in search of a boy.

There is also a conspicuous change in the pattern of expenses regarding conduct of marriage. Traditionally in many of the caste-groups the marriage expenses were met by the groom's parents. Now there are many instances of girl's family asked to meet all expenses. Apart from this the parents of the groom ask for and insist upon certain amount of jewellery and other gifts to be given. The parents of the girl have to wait for a few years to gather money for this.



The parents of an educated boy are looking for a girl who is also educated. This leads to girls spending more time in schools than in the traditional households. Another equally interesting fact revealed by the parents is when the girl is educated and when she goes for a job, she can also earn before marriage, save money to augment resources for marriage expense and to meet some of the expenses related to jewels and other household utensils.

Educated parents are aware of the ill-effects of early marriage on the health of the girl. It is also their desire to provide economic security for the girl. If the girl is educated to a level which could help her secure a job then she can also contribute to the family exchequer which will make both ends meet without difficulty. In case the husband does not take care of the girl the education and the potential of getting a job would act as security for her and her children.

Parents do not hesitate to select a groom from a place away from their own village in order to provide better life to their daughter which delays marriage.

The influence of peer groups also results in postponing marriage. In the urban areas girls are educated and they go for jobs. They like to have a groom who is at least equally educated and having a good job. There are educated girls who are willing to marry after they attain good occupational status.

Many know about the ill effects of early marriage through radio broadcasts. Even in villages, possession of transistor radios is common. So radio, television and cinema also act as forces to delay marriage.

In lower middle class families which are settled in the towns during the present generation, the girls are used to urban way of life and urban way of thinking. Parents of such girls think that they cannot adjust in the village or they cannot do agricultural work. Such parents have to find a suitable match from an urban area which is difficult to get.

## **FINDINGS ON METHODOLOGY**

Initially there was less enthusiasm among the family members to discuss about very intimate family details with the researchers. Later on they were very free to talk with them about all matters. The participation of the women of other families and girls of prepubertal age were helpful to get pointers for discussion. They volunteered to give information about the families in which marriage proposals were about



to be discussed so that the researchers could go to their houses and discuss relevant details. Involvement of all people, especially women, not only those of the families of target children was instrumental in smooth running of the research.

The discussions with the village women and girls had not revealed all the personal matters about the families. Nevertheless they were useful sources of information. Full details were obtained only through personal contact with the individual members of the family although discussion with group of relatives helped. Involvement of the key individual member of the family and her free discussion were mainly responsible for success of this research.

## ACKNOWLEDGMENT

This is part of a study funded by the Population Council, New York. We thank all the social scientists and the people involved in this.

## REFERENCES

Caldwell, J.C., Reddy, P.H., and Caldwell, P. 1982. The causes of Marriage Change in South India. Presented at the International Seminar on "The Social Context of Demographic Change", Bangalore, September 6-8, 1982.

Dubey, D.C., and Bardhan, A. 1978. Status of Women and Fertility: Case Study of a Tribal Group. *Demography India*, 7(1&2): 91-104

Fernandes, W and Tandon, R. (eds.) 1981. *Participatory Research and Evaluation*. New Delhi: Indian Social Institute.

Goyal, R.S., 1979. Changing Attitude Towards Family Planning: A Status study. *Demography India*, 8:116-172.

McDonald, P.F., Social Change and Age at Marriage in IUSSP (ed.) 1981. International Population Conference, Manila, 1981, Vol. 1, Liege IUSSP, 413-431.

Ruzicka, L.T. (Ed.). 1977. *The Economic and Social Supports for High Fertility (Family and Fertility Change)*. Canberra: Department of Demography, Australian National University.

Srinivas, M.N., 1977. Just Raising Age at Marriage will not Do. *Yojana*, 20:33.



TABLE 1

## Number of girls covered by the 'Indepth' study

Village/ Area	Development Status of Village/ Area	Total Unmarried girls taken for study	Married during the study	Population of Village/ Area
<b>Rural</b>				
a. TN	Less	70	17 (24.3%)	2450
b. CH	Intermediate	68	14 (20.6%)	2329
c. KV	fair	84	17 (20.2%)	3438
Total		222	48 (21.6%)	
<b>Urban</b>				
1. SB	Less	89	7 (7.9%)	14672
2. KS	More	83	12 (14.5%)	13260
Total		172	19 (11.0%)	

TABLE 2

## Involvement in Decision Making Process

Persons in Decision Making Process	No. of Marriages			
	Rural		Urban	
	No	%	No.	%
Involvement of all 3 generations	10	20.8	1	5.3
Mostly Involvement of 2 generations (Parents and Grand Parents)	11	22.9	9	47.4
Involvement of parent and current generation (bride or groom)	13	27.1	4	21.0
Involvement of Bride and groom only	13	27.1	4	21.0
	1	2.1	1	5.3
Total	48	100.0	19	100.0



# PARTICIPATORY MONITORING OF FAMILY WELFARE METHODS PRACTICES IN THE COMMUNITY MOTHERS

*Dr. D. Jegadeesh Ramasamy*

## INTRODUCTION

Family Welfare Programme has been implemented since years, in India. The programme has been monitored and evaluated quantitatively and qualitatively by the government agencies at different levels and at different intervals. There are various dimensions to make the community participate and many attempts have been made to involve the community at every stage of health programme implementation, right from planning. People may even be involved to monitor, whether doctor or staff is attending the centre regularly or the drugs are available or not, etc. But, such sort of monitoring others' activities or the system's failure by the people, may yield no result or even end in conflict and adverse effects in due course. Being the beneficiaries and the very sources of informations, the community members, themselves could collect data on programme implemented and further may even analyse, interpret and act. Making them to collect such data will be a type of mutual monitoring, between the provider agencies and beneficiaries apart from self evaluation. Thus an attempt has been made to explore the potentiality of data collection on family welfare methods practice by mothers for whose health and development, that programme is being implemented.

## OBJECTIVE

To identify the potentiality of the community mothers to monitor family welfare methods adoption practices amongst themselves, through enumeration.

## METHODOLOGY

A village belonging to a health Sub-Centre where Health Worker (Female) was not staying in her area due to various reasons was selected. The said worker was also on long leave during the survey period. The village having a population of 1988, located about 30

---

*Dr. Jegadeesh Ramasamy, M.D;D.H.E.,  
Principal, Health and Family Welfare Training Centre, Madras-600008*



Kilometres away from Madras city was selected for the study. Local literate volunteer mothers of 15 to 45 years were given pretested proforma in local language (Tamil) and requested either to furnish informations for themselves and or to collect from neighbours relatives, whoever would be responsive to them. No sampling technique was adopted to collect data. They were just briefed on the spot, ascertaining whether they were willing and able to read and write and fill the self explanatory questionnaire and to collect data from the 15-45 age group mothers. One mother might collect informations from any number of responsive mothers of the same locale. It was carried out between 8 and 11 of November, 1993. In certain instances forms were distributed on the previous day and collected on the next day since they expressed of such convenience. A faculty member of our training centre was a passive observer only, while the data were collected by the community mothers amongst themselves. These data were compared with the data already available in the Health Workers' registers.

## RESULTS

192 formats were collected in 4 days. Of these, two were not filled and returned blank; 6 were related to above 45 years of age. Thus, 184 forms were analyzed and tallied with the registers. 118 found a place in the register of the staff. Of these 118 eligible couples, mothers could enumerate that 57 had undergone tubectomy, when compared to the staff's registration of 146 tubectomies out of 245 eligible couples. On observation, one may conclude staff's enumeration and registration of tubectomy appeared to be better than the mothers enumeration. But while applying the chi square test, the difference is insignificant,  $P < 0.01$  with degree of freedom =  $\chi^2 = 4.11$  (Table - 1)

In addition to the information regarding the acceptance and adoption of tubectomy, information regarding the practice of temporary methods of family welfare were also elicited by the mothers amongst themselves. They could elicit information from 11 mothers about IUD out of 19 (57.9%) as per worker's register. Of these 11, 3 mothers gave back their filled in questionnaires, disclosing that they were still retaining IUD. Similarly, they gathered information about the using of oral pills and conventional contraceptive (Nirodh) (Table 2). Apart from family welfare they came out with other information about the regularity of menstrual period, problems during menstrual period (33) abortion history (18) leucorrhoea (22).



## DISCUSSION

In a very short time of 4 days with a little briefing, mothers could collect so much informations both general, as well as specific, related to obstetrics and family welfare methods practices. There might be lot of consultation within and among the social group members, before and after the adoption of family welfare methods. When it was so, there would not be any difficulty to collect informations regarding that, amongst themselves and by themselves. The mothers had no inhibitions either to elicit or to reveal sensitive informations of family welfare methods practices. This was obvious even to have the informations on temporary methods practices, menstrual problems and leucorrhoea. Since to these mothers whoever could read the questionnaire and write the particulars, the proforma was distributed, it was felt that not much of emphasis need be given to the real literacy level of enumerators. Similarly, since it was the collection of data by themselves amongst themselves purely on voluntary basis, the number of interviewers was not taken into account and rather capitalising as many interactions between neighbours and relatives of the same locale was considered important which yielded data of 194 couples in 4 days. Usually, one or two months, once a year for updating eligible couples and the same period once in three years for enumeration are being spent by the staff. The study has come out with the inference that community mothers themselves can be entrusted upon to collect such basic data without training and the same can be relied upon. If more sophisticated informations are needed, that also could be tried upon with the mothers after due training. Moreover, collection of informations amongst themselves, by themselves, might be more free without reservation than by third person/agency and might save time and cost. If it is so, the staff could devote much more time on technical skills and services.

When people themselves are involved in collecting data about the programme implemented for their health and development, that would sensitise them, make them to evaluate themselves, and would lead to action. This we could observe during our follow up visit after one month of survey, that two mothers had adopted family welfare methods (IUD and sterilization) which might have occurred after lot of interactions amongst themselves, about the pros and cons, between satisfied adopters and non adopters. Such sort of participatory monitoring by enumeration by the people amongst themselves may also be a step or process towards empowerment.



## ACKNOWLEDGEMENT

I gratefully express my thanks to Sandhanapuram village mothers, staff of Primary Healthy Centre, Othivakkam, all staff of our training centre and Director of Public Health and Preventive Medicine, Tamil Nadu.

**TABLE 1**

**Enumeration of Tubectomy by Staff Vs mothers.**

	Eligible couples	No. of tubectomy	
		Done	Not Done
Staff	245	146	99
Mothers	118	57	61
d.f. = 1	$\chi^2 = 4.11$ $P < 0.01$		

**TABLE 2.**

**Particulars collected by mothers tallied with the registers**

	As per worker's register	Mothers Enumeration tallied with register
Eligible couples	245	118
Tubectomy	146	57
IUD	19	11
O.P.	2	2
C.C.	10	1



## **Section V**

---







# **REPORT OF THE PRE CONFERENCE WORKSHOP OF SEARB, IUHPE. ANDHRA PRADESH CHAPTER**

## **1. BACKGROUND OBJECTIVES AND OUTCOME**

It is now widely recognised that substantial improvement in the health status of a population can only be achieved through the combined efforts of a wide range of social, economic and health development. Health is not the responsibility of the health sector alone and that collaboration of other social and economic sectors is also vital for its success.

Health promotion has been defined as the process of enabling people to increase control over the health and to improve it. This process places emphasis on personal participation, supportive environment and the shared responsibility of all sections in improving individual and collective health.

## **OBJECTIVES**

1. To review the present status of people's involvement in the promotion of programmes aimed at Health and Development of Women and Children in India.

2. To identify socio-cultural, economic, administrative and political factors influencing people's involvement in the promotion and development of women and children.

3. To evolve practical guidelines for involving people in the implementation of health and development programmes particularly of child survival and development, safe motherhood, family welfare prevention and control of AIDS etc in India.

## **EXPECTED OUTCOME**

"Guideline on People's involvement in the promotion of programmes aimed at health and development of women and children in India especially,

1. Child survival and safe motherhood.
2. Family Welfare Programmes
3. Prevention and control of HIV/AIDS

---

*Report on workshop - Andhra Chapter of IUHPE, C.C Shroff Memorial Hospital 3-4-801, Barkatpura, Hyderabad - 500027.*



## 2. PROCEEDINGS OF THE PRE CONFERENCE WORKSHOP

The workshop proceedings included a formal inauguration session, information session, group discussion and a valedictory function. At the inaugural session, Dr.S.C.Bhargava Unicef representative raised three points viz i. how to reduce child mortality rate 2. how to reduce malnutrition among children and expected mothers and 3. how to educate our women. He asked who shall we entrust this responsibility. Is it to Panchayat Raj or the Voluntary Organisations or Government or to anybody else?

In her presidential address Mrs. Nandini Gandhi explained the alarming situation in regard to poor health of women and children. She said that nearly half a million women in the reproductive age group die every year from pregnancy and child birth. In many developing countries atleast half of the deaths of children aged under one year occur during the first month of life. These are caused by the mother's poor health before and during pregnancy, unsafe child health practices and inadequate care immediately after birth. The component of mortality is dominated by endogenous factors such as low birth weight and congenital disorders. In her remarks she said, that there was a great role for the community to participate in all these efforts. Community involvement is essential for awareness leading to action. This awareness and involvement can come through the right kind of educational approach which result in self care and self help and a meaningful interlocking between the community and the health care providers.

Dr.(Mrs.) Geetha Reddy, Honourable Minister for Culture and Tourism inaugurated the workshop. She stated that we are striving hard to implement the recommendations of the WHO which are designed to improve the health of the people. Social, cultural and economic aspects are getting attention as the health programmes are tenaciously inter linked with them. The war against illiteracy has also been taken seriously. Immunization Programme has been vigorously implemented with the result that more than 90% of children are covered in India. She however stated that we can achieve much greater progress if we can involve the people in planning and implementing the above programme.



The information session consisted of talks by experts on the following topics :

1. Health status of women and children in India.
2. Development status of women and children in India.
3. Participation of Male sector in improving the health and development status of women and children in the country.
4. Voluntary organisation's and people's involvement in improving the health and development status of women and children in the country.

After the information session, the participants were divided into 3 groups to discuss and develop the guidelines on 'People's involvement in the promotion of programmes aimed at Health and Development of the Women and children in India especially:

1. Child survival and safe motherhood.
2. Family Welfare programme.
3. Prevention and Control of HIV/AIDS

The closing session was chaired by Dr. H.C. Upadhyay noted Journalist and a Lawyer. The rapporteurs of 3 groups presented the reports and these were followed by general discussions and decision.

The recommendations arising out of the three group discussions are annexed (see next page).



## **ANNEXURE TO PRE CONFERENCE REPORT OF ANDHRA PRADESH**

The Rural Population and Urban Slums are in greater need of Health Education and Primary Health Care. Therefore guidelines for reaching these segments are:

1. In addition to government agencies, Panchayat's formal and in-formal leaders, teachers and students should be involved in Health Education and Nutrition Programme.

2. Establish person to person contact (youth to youth approach) Health Workers to Mother. It should be established through mass media, television, folk dance and music.

3. Urban slums should be covered by Urban Family Welfare Centre for 50,000 population. This includes a Medical Officer and Para Medical Staff. They should promote child survival safe motherhood strategies.

4. Orientation in Health and Nutrition should be given periodically to all levels of Health Workers, at district and mandal level.

5. Monthly meetings of Anganwadi, Mahila Mandals, Youth Clubs in Health and Nutrition are to be conducted.

6. Pregnant ladies, mother-in-laws and husbands should be educated in respect of registration of pregnant ladies at Health Centre as early as possible, to avail the facility of giving Immunization, treatment and Antenatal checkup and supervision.

7. In long term programme-school teachers and students should be involved in Health Education of the mother and children, especially on nutrition and hygiene. Students should be the future force to educate the community.

8. Focus on Girl Child and adolescent girl should be given. Formal and informal education in child rearing and health and nutrition in rural setup and urban slums to be strengthened.

9. Child survival strategies should be promoted with universal "immunization," Control of Diarrhoea" and "prevention of ARI diseases".



10. Co-ordination should be established between Government agencies and voluntary organization to strengthen the Health Education Programme.

## **FAMILY WELFARE**

The participants felt the need for greater involvement of people in Family Welfare Programmes, to help in bringing down the birth rate and to shift people's perception of Family Planning as a Government Programme to people's programme.

Formation of village health committees will assist people to discuss their needs, identify the priority areas and create a situation which will help in taking own decision, set goals and formulate as well as implement the programme.

Barriers to successful Family Welfare Programme identified by the Group were: Fear of officials, vested interest, education, health, distance between officials and people.

In order to reduce these barriers the group felt, involvement of :

- a. School Teacher and Headmaster
- b. Formation of neighbourhood committees in urban areas and involvement of formal and informal leaders in slums.
- c. Establishment of strong rapport with local voluntary groups viz., youth clubs, Mahila Mandals, Bhajan Mandals etc. which will help in promoting the FW programme.
- d. Mobilise and train the interested individuals and make use of them as MOTIVATORS.
- e. Encourage community members to form co-operatives and work together for their development.
- f. The group has identified the priority areas and groups, with which it has to work namely:
  - a) Identify young couples of age group of 20-24 years.
  - b) Encourage the people to delay the age of marriage from 18 to 20 years.
  - c) Registration of marriage is to be introduced like birth and death registration.



- d) Inculcate the message of importance and benefits of delayed marriage among the adolescent girls.
- e) Family is to be taken as a unit for health services.
- f) Give greater publicity about spacing methods.
- g) Effective treatment for couples having 1 or 2 children.
- h) Identify the accepted motivators among the community and use him/her in spreading the information through men to men and women to women and form 'Acceptors Club'.
- i) Enhance the general education.
- j) Motivate the mother's during ante-natal (post-natal) period which will help in boosting the F.W. Programmes.
- k) Conduct and orient periodically the leaders and keep in regular touch.
- l) The services to be qualitative.
- m) Family Counselling Centres to be introduced.

## **PREVENTION OF H.I.V / AIDS**

The group agreed that AIDS is an infectious disease and there is no vaccine against AIDS., and it is noncurable and health education is the only preventive measure.

The group made the following recommendations.

1) Awareness sessions have to be conducted particularly to the high risk groups and in general to all including students. The group has identified the following high risk groups.

- a. Persons who have STD (Sexually Transmitted Diseases)
  - b. Persons who have many sexual partners (Prostitutes)
  - c. Rickshaw Pullers, Truck Drivers
  - d. Navy, Military, Army personnels.
- 1) Awareness Generation Programmes on AIDS have to be arranged in schools, colleges, villages and in slums.
  - 2) Workshop on HIV/STD/ AIDS for prostitutes, rickshaw pullers, lorry drivers should be arranged from time to time.
  - 3) Street-plays on how the AIDS virus spreads, how to prevent the spread of AIDS and safe sex.



- 4) Formal and informal leaders, members of youth clubs, mahila mandals, to be oriented.
- 5) Condom distribution centres to be established at outskirts of the cities, Red light area, and other important centres.
- 6) Every Hospital should have an AIDS counselling centre.
- 7) Contact tracing - i.e. partner notification to be introduced as it will help in preventing further spread of the diseases.
- 8) Sex Education/Reproductive health for adolescents to be introduced in high schools and colleges.
- 9) Efforts to be made to disseminate information on the prevention of HIV/AIDS in hotels/ bar and restaurants bus stands railway stations / Airport and other important public places.
- 10) Screening of blood for the high risk groups to be intensified.
- 11) Social stigma attached to HIV/AIDS Patients to be removed through suitable educational program.
- 12) Training of HIV/AIDS/STD for RMPs and Para Medical Persons to be arranged.



# PRECONFERENCE WORKSHOP

## KERALA CHAPTER OF SEARB, IUHPE

*Dr. K. Balachandrakurup.*

The Pre-conference workshop on the theme 'People's involvement in health and development of Women and Children', originally scheduled to be held in November'93 was held at Trivandrum on 15 Jan. 94. The target participants were drawn from grass root level workers of Social welfare Department, Health Services Department, Nehru Yuvak Kendras, Sasthra Sahitya Parishad, Saksharatha Samithi and Arogya Vijnana Kendra of the IUHPE. 50 participants and about 20 resource persons from IUHPE attended the workshop.

The inaugural session started with the welcome address of Sri A.K. Somasekharan Nair (Joint Secretary, Kerala Chapter). Sri Rosscote Krishna Pillai (an eminent educationist and media expert formerly with the Indian Information Service) inaugurated the workshop. Dr. K.Balachandra Kurup (General Secretary, Kerala Chapter) presided over the function.

Before the workshop the participants were briefly oriented as to how the discussions should proceed and they were asked to do a situation analysis, on various aspects affecting health and development in their respective sphere of activity. For creating greater interest among the participants Dr. Remani Wesley (Assistant Professor, Regional Cancer Centre) spoke on cancer control programmes and the role of the community leaders identifying early detection of cases. Several slides were projected to illustrate the severeness of this dreadful disease. Dr. G.Haridas (Addl. Director, AIDS Control Programme, Kerala Health Service) delivered a talk on AIDS in India and Kerala and the control programmes and the need for the hour. Smt. K. Baby (District Programme Officer, ICDS) presented the theme paper on people's involvement in health and social welfare programmes, challenges ahead. After the deliberation by resource persons there was lengthy and very fruitful dialogues and interactions between the recipients and programme implementors.

The main recommendations came out of the deliberations are as follows:

- i. The participants felt that there should be several improvements in the programmes implemented by the Social Welfare and Health



Departments. There are few limitations in the supplementary feeding programmes and the workers are not communicating the correct information about the availability of food materials with the womenfolk. Irregular supply of Vitamin A and folic acids, no regular medical check ups for pregnant and lactating women and children, no systematic deworming camps for children and lack of general medical check up facilities for the school children. The participants suggested that a close coordination between the social welfare and health department is essential for creating an healthy atmosphere for improving the quality of life and living conditions of women and children in the society. (Attention: Director of Health services and Director of Social Welfare)

ii. The School Health programmes exists in paper only. This has to be revitalised with increased participation from the health, education department and Parent Teachers Association. As prelude the PHC medical officers in each locality should be given the mandate and the required resources for starting the school health programme. (Attention: Director of Health Services and Director of Public Instruction.)

iii. The facilities given to antenatal and post natal care in the highly density coastal areas and colonies are quite inadequate. The health programme strategy has to be augmented for benefiting the vulnerable groups. Increasing efforts should be given to reactivate this programmes for benefiting more persons (Attention: Director of Health Services and Director of Social Welfare)

iv. Blood grouping facility should be made available at the grass root level especially for the women and children (Attention: Director of Health services and Public Health Laboratory).

v. After hearing the importance of a once in a year pap smear test in preventing cancer of the uterine cervix, the group felt that pap smear facility may be made available once in an year in every subcentre (Attention : Director, Regional Cancer Centre).

vi. The group also felt that there is a need for epidemiological studies on water borne diseases in the coastal belt. Considering the high incidence of diarrhoeal disease the participants suggested that epidemiological studies should be carried out on a continuous basis for planning suitable interventions. Similarly diseases like cancer, heart diseases, chronic obstructive lung disease etc are common in this locality (Attention: Director of Health Services, IUHPE Kerala Chapter is to take the lead in arranging this)



vii. There should be provision to regularly monitor the water quality standards at the grass root and the Public health Laboratory should undertake this. The voluntary groups should be trained to carry out the necessary treatment. Good quality bleaching power should be made available in small packets of 25-30 grams (Attention: Director Health Services, Kerala Water Authority and IUHPE, Kerala Chapter)

viii. The literacy workers and teachers felt that they may be trained for disseminating important health messages during the regular literacy programmes. Health education leaflets and other software packages may be developed for use in the programme. Similarly literacy workers should be given appropriate orientation in delivering better services to the community (Attention: Literacy Mission and IUHPE Kerala Chapter).

ix. The ICDS workers who are doing excellent job for the health, social development of women and children through their anganwadi felt that their allowance is very meagre and maybe enhanced.

x. The volunteers from the Argya Vignana Kendra of the IUHPE, Kerala Chapter requested that a permanent model Exhibition set on AIDS, Cancer etc should be developed at the centre to enable tourist (mainly from other parts of Kerala and India) to understand the prevention and spreading of such devastating diseases. This centre is located 3 kms away from an important Tourist spot.

xi. The group felt that there should be integrated package of activities for promoting the health and development of women and children. All extension workers should be given training to use these packages with suitable health education materials.

xii. The most important recommendation was that local community groups with more women members, who are the actual beneficiaries, must be constituted for planning, implementing and monitoring the various programmes especially in the interior and neglected areas like the coastal belt, hilly regions and so on.

xiii. For enhancing the family income of women, which can to a certain extent, help the development, through small scale industries to be financed by Government, was a recommendation which was mostly accepted and highly appreciated by the group.

xiv. The school health education programme has to be reinforced at the PHC level. The medical officers responsible for this programme has to be motivated in conducting periodical medical check up at the school. A proposal has to be developed by the IUHPE Kerala Chapter together with the Education and the Health Department.



# **PRECONFERENCE SEMINAR KARNATAKA CHAPTER OF SEARB, IUHPE**

## **PREAMBLE**

The Karnataka Chapter in collaboration with the Department of Health and Family Welfare services, organised a pre-conference seminar on 'People's involvement in programmes aimed at child survival and safe motherhood' at Anekal, Bangalore Urban District, on 25th November 1993. Officials of Health Department, health related Departments, representatives of voluntary organizations and people's representatives participated. The objectives of the seminar were :

- 1.1. To Orient the participants on the importance of people's involvement in the child survival and safe motherhood.
- 1.2. To discuss the various problems and difficulties encountered in the implementation of child survival and safe motherhood.
- 1.3. To elicit the participants views and IDENTIFY the manner in which they can play a key-role in the promotion of health of women & children.
- 1.4. To identify the areas of effective coordination between the Departments in the promotion of health of women and children.

## **2. SEMINAR ORGANISATION**

A Planning Committee, consisting of persons with different background, experience and expertise in the field of health was constituted to plan the conference. The committee met thrice in Bangalore and discussed the various aspects of the seminar. A draft programme was circulated among experts before its finalisation. The seminar was jointly organised by the State Department of Health and Family Welfare Services and the Karnataka Chapter of the SEARB, IUHPE in order to achieve the objectives of the seminar. The participants included taluk level officials of health and health related Departments, representatives of Voluntary Organisations and people's representatives. It was not possible to include the elected representatives since Zilla Parishad elections had since been postponed. All participants were properly briefed even before the conference through individual contacts, circulars printed folders etc. The participants were given the basic knowledge about the seminar, content for discussions etc so that they could actively participate.



The Directorate of Health and Family Welfare Services arranged an exhibition during the seminar highlighting the care of pregnant mothers, prevention of childhood diseases and immunization against them. A panel discussion, where the members were properly briefed also was part of the seminar.

Mr. C. Somasekhar, Special Deputy Commissioner, Bangalore Urban District, inaugurated the seminar. In his inaugural address, HE COMPARED THE LIFE OF THE MOTHER TO THE LIGHT OF THE LAMP. The light can show the way in the dark if oil is provided. Similarly, the mothers can throw light on the entire family if her health is restored. In the process of creating a conducive healthy atmosphere, he stressed the need for peoples' involvement.

Dr. C.R. Krishnamurthy in his presidential address narrated the purpose of the seminar and requested the participants to EXPRESS their views and suggestions to improve the programme.

The participants were divided into two groups for group discussion. All the health and health related department officials formed one group. The representatives of the Voluntary Organisations and people representatives formed the second group. Each group was assigned with a resource person. The groups were also supplied with guidelines for discussion.

The following are the recommendation of this seminar :

### **BLOOD GROUPING FACILITY**

- All the hospitals of taluk must have facilities to find out the blood group which would benefit the life of the mothers during emergencies.
- Organising blood group detection camps to detect the blood group of pregnant women is necessary and cards issued thereof.

### **VACCINES**

- It would be necessary to supply sufficient quantity of immunization cares and vaccines for continuous activities.

### **ANALYSIS OF WORK LOAD**

- The Junior Health Assistant (Female) who is the main functionary for child survival and safe motherhood work is over loaded with other work. Therefore, it would be desirable that she should be allowed to concentrate more on this programme



## **TRAINING**

- The departmental officers working in various levels have to be trained immediately.
- Dais trained long back, should be given retraining.
- Organising training at the Panchayat level would be useful.
- Providing training to the concerned staff when blood group detection is necessary
- A separate training programme may be arranged to those persons who are particularly interested in social work

## **ADMINISTRATIVE MANDATE**

- The higher officials (taluk level) need to send administrative circular to the lower staff to cooperate in the programme.

## **INTER - SECTORAL CO ORDINATION**

- Inter-Sectoral Co ordination to be strengthened under Zilla Parishad, the Deputy Secretary (Development) should be made responsible to monitor.
- The Junior Health Assistant (Female) and Anganwadi workers should have more co ordination and joint programmes.

## **SMALL FAMILY NORM**

- Help mothers to advocate small family norm and to become more healthy

## **EMERGENCY FUNDS**

- The village level organizations may mobilise some emergency funds to meet the exigencies of pregnant women.

## **MOTIVATION**

- Ignorance among the people is the main problem. Therefore, it was recommended that the voluntary organisations and people's representatives will become educators to motivate them.



## **REFERRAL SERVICE**

- In the absence of services of Female Health assistant during delivery, The trained Dai's help could be taken and later sent to hospital.

## **SUPPLY OF KITS**

- Sufficient delivery kits to be supplied

## **ENERGISING SERVICES**

- One of the most important outcome of the seminar was the people felt that proper services are not forthcoming by the hospitals. As such, their involvement would bear no fruits. Therefore, provision for service facilities to be strengthened and adequate.

## **GRASS - ROOT LEVEL MEETINGS**

- Village level meetings should be organised atleast once in three months.

## **INVOLVEMENT OF WOMEN**

- It would be more useful and productive to involve the local village organisations, especially women organisations and youth clubs.

## **SCHOOL HEALTH EDUCATION**

- School health education should form part of the school syllabus so that the younger generation will develop health habits.
- Male Health Assistants shall also take part in the programmes of child survival and safe motherhood with specific reference to immunisation and health education.



# **PRE CONFERENCE SEMINAR TAMIL NADU CHAPTER - ROLE OF TEACHERS WITHIN THE SCHOOL AND IN THE COMMUNITY**

*Dr. Prithivi*

School teachers can play an important role both in the school and Community, in monitoring the health and development of women and children. In order to focus on this aspect and learn more on what role teachers can play, The Tamil Nadu Chapter decided to conduct a pre-conference seminar exclusively for School teachers of Tamil Nadu for two days. The conference was organised at Madras on 20-21, Nov, 1993.

As a first step, a working committee that was constituted to work out the details, met the Director of School Education and had discussions with him. He agreed to depute about 50/60 teachers at the rate of two teachers per district for participating in the Seminar. The chief educational officers were requested to depute the teachers from high/higher secondary schools under their jurisdiction. The venue was Health and Family Welfare Training centre, Egmore, Madras. Accommodation was arranged in the same place. The T.A. and D.A. for the participants were met from the State funds by the respective C.E.O's as per the rules.

About 86 teachers participated in this 2 days Seminar. The Seminar presided over by the President TAMSEARB Dr. A. Ramalingeswara Rao was inaugurated by Dr. C. Palanivelu, Director of School Education. Dr. P. Krishnamoorthy welcomed the gathering and explained the purpose of the Seminar. A panel discussion was held by a team of members - Dr. V. Kapali, Dr. C.T. Sambandham, Fr. Emmanuel Mariam Pillai, Dr. Kodimani and Dr. P. Krishnamoorthy. Dr. Sumathy S. Rao explained the programme and the advantage in teacher participation in working out the details.

The following reading materials were given to the participants (Teachers) for orienting themselves to take part in the Seminar :

1. Parents role & responsibilities in School Health Programme.
2. Students role and responsibilities in School Health Programme.
3. Teachers role and responsibilities in School Health Programme.



4. School Health Programme.
5. Common ailments detection and management among school children.
6. Methods & Media in executing the School Health Programme
7. Teachers' role in child to child programme.
8. Role of teachers in the control of Diarrhoeal diseases
9. Health club in schools.
10. School as change agent in Health promotion.

The participants were divided into ten groups. The following topics were given for discussion :

1. Health appraisal of School students.
2. Teachers' role in improving the health of the Community.
3. Areas of Co-ordination, between Health personnel and teachers.
4. Incorporating health content in school curriculum.
5. Motivational points to child to child programme.

Two groups were given the same topic for discussion. At the end of the group discussion each group consolidated their recommendations. The valedictory function was held on 21.11.93. Each group presented their recommendations to the benefit of other members. Following that Sri. S. Paramasivan, Director of Elementary Education delivered the valedictory address.

A summary of the recommendations of the groups are given below :

## **GENERAL RECOMMENDATIONS**

- Through Child to Child Programme Health Education can be given to other children, family members and to the other members of the Society. For this the child can be educated in three different ways (a) Learning from others (b) through books (c) through demonstration method.
- Health related topics should be integrated into the regular curriculum.
- In the School curriculum a seperate subject "Health Science" may be introduced.



- A separate period should be allotted for "Health Education" and in the examination Health related questions should have a place and marks should be allotted.
- According to the Students' age and class the following health related materials should be prepared and used :- pictures, charts, cartoons, leaflets, drama skit, folk songs, puppets, songs, short stories, dialogues, quiz, elocution competitions etc.,
- Medical examination and for the students should be conducted atleast once in a year. For this, teachers & Health personnel should jointly work. The follow up action should be carried out. The cumulative health cards should be preserved properly.
- For the healthful living in the school, the necessary health facilities should be provided in all schools.
- The member students of the following organisations viz., Junior Red Cross Society, Scouts, guides, N.S.S., N.C.C., Health Committee should be utilised for health promotion activities in their area.
- The Health lessons should be included in the text books. Health principles, explanatory pictures, Do's and Dont's etc., may be printed in the backside cover page of the text books.
- In the school, during the morning assembly time, a few minutes may be allotted for health talk to all students.
- More of Health Education training should be given to the elementary school teachers. In-service training on Health Education should be arranged for the teachers.
- The Parents Teachers Associations should be utilised for the promotion of Health.
- During the fairs and Festivals Health Exhibition may be organised. The other activities such as health songs, puppet show, health drama may also be arranged during that season.
- The radio and Television programmes should telecast the health education programmes for student population.
- The health education committee should be formed. This Committee should take an active role in organising health education activities during the special days such as W.H.O. Day, Women's



day, Disabled day etc., This committee should involve the local people in uplifting the health status of their area.

- During the various health related camps, the students should be motivated to take active part in camps.
- Students, teachers, health personnels and parents should meet atleast once in a month and discuss about the various activities related to the improvement of the health.

## **GROUP I**

### **TOPIC: HEALTH APPRAISAL OF SCHOOL CHILDREN**

- The cumulative health cards should be properly maintained. Necessary help should be rendered in rectifying the recorded defects.
- Twice in a year the School Medical inspection should be conducted in the school. If not possible atleast once in a year the medical inspection should be conducted.
- Before conducting the medical inspection the group consisting of the Headmaster, teachers, Medical Officer should meet and discuss about this.
- The teachers should do the continuous follow up of the cases referred for treatment.
- The Health education in-service training should be given to the teachers.
- The records should be maintained in the School and proper immunisation given for the students.
- The Scouts, Red Cross Society, N.S.S. can be organised in the Schools where the number of students are high and they can be utilised for improving the health condition of that area.
- When they collect special fees in the school, a seperate amount should be collected for Health Education, apart from the money collected for medical examination.
- In the time table a seperate period should be allotted for Health Education.
- Health Education Committee should be formed in the school for bettering the health condition.
- Health related topics should be made as examination subject and seperate marks should be allotted.



- The Health Education trained teachers should be appointed in the school and through them the health education awareness should be created.
- The water should be protected by the method of chlorination and the same should be provided to the students.
- Through Parent- Teachers' Association the parents should be enlightened to take care of the health.
- Once in a week health related functions may be organised and in that dramas on health, Puppet shows, games, film shows can be conducted.
- The Health Education Programmes should be broadcasted in All India Radio, Television for the benefit of the school students.
- Out of the school hours the teachers should select leaders from the community and through them the health awareness should be created among the people.
- Health Committee should be formed in the school and during special days like W.H.O day, the health awareness can be created in the Public by conducting processions in that area.
- On special days like W.H.O day the health education awareness may be created by giving special explanations during the morning assembly.
- The diseases and their prevention can be depicted in pictures and they may be exhibited in the public places of the school premises.
- By using the Snellen's chart, class by class the eye defects may be detected.
- Quiz Programme on health may be organised in the school.

## **GROUP II**

### **TOPIC: TEACHERS ROLE IN IMPROVING THE HEALTH OF COMMUNITY**

- The children who have got some symptoms of diseases should be followed and necessary advice should be given to get treatment from the Medical Officer.



- The opportunities should be created for the students to keep the School and house environment clean.
- The student members of N.S.C, N.S.S, Scouts, Red Cross Society should be given training in Health Education and with their help the health status of the community should be improved.
- During the school holidays the students should be taken to nearby village and through students the Community should be educated on health. The expense for this should be collected from the prestigious people of that village.
- During the parent-teacher's Association meetings the teachers should highlight the health messages to the mothers.
- The teachers may contact the local health authorities and explain to them the prevalence of the diseases in the community and request them to come and take necessary preventive measures.
- During fairs and festivals the students can conduct health oriented cultural programmes. Through enacting the dramas and floats the health awareness may be created and then the health messages can be given.
- During the health camps conducted by voluntary agencies, such as eye camps, the community members should be motivated to participate. The teacher can involve the students and their parents to participate in these activities.
- With the help of the students the teachers should visit their houses and the parents should be educated in the health aspects.
- They should be motivated to develop kitchen gardens and to produce and eat green vegetables.
- They should be educated to build and use the cheap sanitary latrine.
- Health personnel and the community members should have discussions. Teachers can arrange such meetings.
- During the other departmental functions they should participate and give hints on health and they should explain them.



- Television should telecast the health oriented debates and cultural programmes for the public.
- The special guests of the school function should be given a chance to highlight some of the health points.
- Atleast once in a month students, teachers, health personnel and the parents should meet and discuss.

### **GROUP - III**

#### **TOPIC: AREAS OF CO-ORDINATION BETWEEN HEALTH PERSONNEL AND TEACHER**

The health personnel and the teachers can jointly work on the following activities :

1. Medical check up and medical inspection. The dates of medical check up should be informed earlier to the school and the same should be informed to the parents.
2. Maintaining Students Health information register.
3. Recording of height/weight
4. Referring the students for higher level treatment for the defects that are found out during the medical check up.
5. Involving the parents during :
  - The medical check up.
  - Follow up work at community level.
  - Improving the protected water supply.
  - Giving health education.
  - Stressing to get medical help from the hospitals.
  - Immunisation work.
  - Improvement of Environmental cleanliness.
  - Make O.R.T Packets readily available.
  - Community participation.
6. Organise parent teachers association and give health education.
7. Improving the basic health needs of the school.



8. Observing the special health days to create health awareness.
9. Cultural activities, oratorical competition, essay competition can be conducted and awareness can be created through these activities.
10. Special prizes may be given during annual day functions.
11. To render help in organising the health camps.
12. The Specialists should be invited for giving special talks.
13. Organising the leader's meeting and requesting them for donations.
14. Getting donations from others and organise the health camps.

#### **GROUP IV**

#### **TOPIC: INCORPORATING, HEALTH CONTENTS IN SCHOOL CURRICULUM**

- Through "Child to Child programme" the health messages can be imparted to children, family members and to the community at large. The children can be divided into groups and act.
- Through the school subjects by using charts and other A.V. aids the health education can be taught.
- Through the members of the Scout, N.S.S., N.S.C., & health Committee, the health messages can be spread.
- The health messages can be given through pictures, newspaper, Poems, cultural activities etc., and through parent teachers association of the schools.
- Before the class starts the teachers can have discussion about the students health, family's health, protected water, Nutritious habit, personal hygiene, school sanitation and communicable diseases control.
- In the "class subjects" the health examples can be integrated.
- Through exercise, meditation, community work and joint prayer the health messages may be given.
- During the school gardening work the importance of the nutritive food can be taught.



- According to the age the health messages should be given :
  - a. Through Rhymes for 2-5 years age group children.
  - b. Songs, oratorical competition, Drawing competition, essay competition, quiz and cultural activities for 6-12 years age group children.
  - c. For 13-17 years age group students through competition, debates, dramas, mono acting, dance, Folk songs, Puppet shows the health messages can be explained.
- For the personal hygiene, each student may be individually called and educated through discussion method.
- Prizes and praises can be given to the best health maintained student of the class and he can be the model for other students.
- During the school assembly proverbs about health can be highlighted.
- Health oriented pictures should be shown as models and the students should be asked to collect health related pictures to make albums.
- The health messages heard from the A.I.R., and seen through T.V., magazines should be discussed in the class room by the students.
- During the celebration of W.H.O. day, Women's day, Disabled day etc., the students should be encouraged to conduct health oriented exhibitions.
- The students should be trained on the method of making the O.R.T. solution and home available fluids for the persons affected with diarrhoea as a first aid measure.
- In the Mothers - teachers Association meetings, Teacher's parents association meetings the school students' health problems and their solution may be discussed.
- Not only the teachers, the parents as well as the health personnel should be given a chance to highlight the health messages.
- During the school medical examination the parents should be asked to be present and the health condition of the students should be explained to them.



- Nutritious midday meal programme personnel should be given orientation in cleanliness and better methods of nutritive cooking.
- The member students of the N.S.S., N.C.C., Scouts, Red Cross Society should be taken to a village and they should be involved in cleaning the garbages, giving health information to the community by way of different cultural activities such as enacting the dramas, folk songs etc., These will enable the members to have deep and permanent mental registration of health concepts.

## **GROUP V**

### **TOPIC: MOTIVATIONAL POINTS TO CHILD TO CHILD PROGRAMME :**

- In the child to child method, the child should learn to keep himself clean and to practice healthy habits and then teach the other children about these. The child can learn this by three different methods (a) Learning from others (b) Learning from books (c) Learning by doing.
- During the School General assembly five minutes may be allotted for Health messages.
- Make them read the hand outs on Health topics.
- The children should be taken to the unhygienic spots and the ill effects should be highlighted.
- The health topics may be given importance in the following ways :
  - a. Health messages may be integrated along with the school curriculum.
  - b. In the time table a separate period may be allotted for Health Education. A separate subject may be introduced for Health Science.
  - c. In the examination 10 marks may be allotted for health related questions.
- The following methods and media should be utilised according to the students' age and class :

(1) Pictures (2) Charts (3) Cartoon pictures (4) Puppet shows (5) Dramas (6) Folk songs (7) Discussions (8) Debates (9) Short stories.



- Students may be involved in the following activities :
  - a. The students should write some health messages in the information board for attracting the action of other students. Health related slogans should be written on the class room black board.
  - b. According to the situations health exhibition should be conducted. The pictures and the other display materials should be collected by the students. The demonstration methods should have a place in it.
  - c. In order to improve the health knowledge the following competitions may be organised : the quiz programme, Essay competitions, Drawing and painting competition etc.,
  - d. Health committee should be formed and health camps should be organised in order to propagate health related messages to the public.
- Health condition of the school should be maintained properly. The defects should be highlighted to the respective authorities.
- School medical inspection should be conducted.
- J.R.C, Scouts, N.S.S. Members should be involved in the Public Health Programmes during the fairs and festivals.
- Necessary care should be taken to keep the Midday meal cooking shed in a sanitary condition. The children should be educated to cook the food without losing the nutrients of the midday meal.
- The nearby schools should jointly organise the "Health related competitions".
- "Mothers and Teachers Association" of the Primary School should take necessary action regarding the children's health habits.
- More of health education training should be given to the elementary school teachers.
- In Tamil and English language text books, the topics related to the Health and the diseases related to school going children and its preventive methods should have a place.



- Health related points, explanatory pictures, Do's and Dont's should be printed in the last page of the books and work books prepared by the Tamil Nadu Text book society.
- The School students should join with the final year Medical college students and conduct Health related campaigns. Teachers in community medicine (SPM) department and deans of medical colleges and teachers and head teacher of schools shall organise such conjoint programmes.
- The training camps may be organised during the seasonal holidays for the school students.
- The senior students can involve the junior students in cleaning up streets and in keeping the information boards and health talks.
- The students should be made to involve in the eye camp, Dental camp etc.,



## 3<sup>rd</sup> REGIONAL CONFERENCE OF SEARB AND ITS RECOMMENDATION

The SEARB-IUHPE held the 1991-94 election of its office bearers in APRIL 1991. Dr. V.Ramakrishna was unanimously elected as the regional director of SEARB. It elected as members in charge of the conference Dr.V.Kapali and Ms.Padmasini Asurai.

Dr.V.Kapali and Ms. Padmasini met at Bangalore immediately after the election, and on the next day. Dr.Sumathy.S.Rao Secy of TAMSEARB was also present during the meetings. In the course of their deliberations on the plans for 1991-94, the thought of holding the 3rd regional conference during this period was mooted, This idea was later carried on to MADRAS where Dr. V.Kapali., S. Sumathy Rao. met Dr. A.Ramalingeishwara Rao the president of TAMSEARB and persued this thought. Dr.A.R.Rao readily offered to organise the conference in Tamil Nadu if the Exective Comittee, so decides. Accordingly this subject was placed before the TAMSEARB'S Executive Committee (EC) which readily accepted to host the 3rd regional conference of SEARB at Madras or any other suitable place in Tamil Nadu. The subsequent meetings of the EC of TAMSEARB discussed further the details of the Conference Theme, objectives, place of the Conference, Venue etc.,

Sustained involvement of People was identified as the major input for sustained action to improve ones health, and the health of the community. Much work has been going on in this sphere, both sucessful and not so sucessful experiences.It was thought if those who have first hand experiences in involving people can be brought together to share their experiences among other workers in this field, and with adminstrators, planners, and academicians to identify the various factors and circumstances which contribute to successful and sustained involvement it will be highly useful to all practioners of Health Education. Involvement of people has been tried in various P.H. Schemes including M.CH, Malaria Control, Filaria Control, abatement of Mosquito breeding, Fly breeding, providing Safe drinking water, providing Sanitary disposal of human excreta, improving human Nutrition etc. As Women and Children Constitute nearly 70% of the population and as they are more vulnerable in the community it was decided that the Conference can focus on "People's Involvement in Health and Development of Women and Children"



The President and Secretary of TAMSEARB duly informed the regional director Dr. V. Ramakrishna this offer to hold the 3<sup>rd</sup> Regional Conference of SEARB at Madras sometime during last Quarter of 1993 and the main theme of the Conference.

Dr. Ramakrishna, Regional Director SEARB responded to their offer by accepting this offer and noting the timeliness of the choice of the theme and asked TAMSEARB to go ahead working the details of the Conference, based on their past experience. He also sent some "Seed" Money towards the initial expenses for the Conference.

The EC of TAMSEARB met nearly 20 times to work out the details of the conference. Subcommittees were formed based on the experiences of the 1st Regional Conference (1). The details of the subcommittees and the members who volunteered to the subcommittees are in appendix 1 to this write up.

A folder was prepared about the proposed Conference, its main theme and sub theme and the dates of the Conference its Venue and this was sent sufficiently early to all members of SEARB, and to E.C. of the (IUHPE, PARIS). In this folder itself invitation to present papers, posters was included so that members can avail the opportunity to present their experience, views, suggestions on "People's Involvement in Health and Development".

Letters were sent out by the technical Committee to various experts and field practitioners who are engaged in Health and Development activities in Rural and Urban Communities. The very good response for this request and the receipt of many articles well before the date stipulated by us helped us to have these articles printed as a book (Bulletin) and got it released at the Inaugural Session of the conference.

In addition to this publication of invited papers, a selection of published articles were put together as "readings" on People's involvement in Health development, esp in relation to women and children.

The organisers of this Conference thought that as the scope to attend the Conference at Madras is limited to a few of the members in other chapters of SEARB, these Chapters can hold a 'Preconference' Seminar/Workshop, where some aspects of this Subject of People's Involvement in Health and Development of Women and Children can be discussed and their recommendations brought to the main conference. Accordingly Andhra Pradesh chapter, Kerala chapter had preconference seminars. Tamil Nadu also had arranged a workshop



with Members of the School Education Department realising the importance of the role of Teachers, and the Students in initiating, strengthening sustaining the momentum of People's Involvement in Health and Development. The report of these preconference workshop/seminars are printed in this volume. See Page : 327 - 380

The 3rd Regional Conference was held as scheduled on 20-21-22nd Jan 1994 at Madras in the auditoriums of Guild of Service and School of social work.

Nearly 250 participants took part in this conference. List of participants annexed. The participants have come from International Union of Health Promotion and Education, from IUHPE Regions of Europe, Australia, from SEARO, WHO, DANIDA, UNICEF, USAID, besides members SEARB from Nepal, Bangladesh, State of Andhra Pradesh, Karnataka, Kerala, Punjab, Gujarat, Maharashtra and Tamil Nadu.

Among the Departments in Tamil Nadu, Directorates of Medical Services, Medical Education, Public Health, School education, TINP, Social Welfare, Corporation of Madras and Madurai actively participated in this conference by deputing some of their field officers interested in Peoples Involvement in Health & Development.

Non-Governmental organisations like Voluntary Health Association of India, Womens Voluntary Services, Guild of Service, School of social work, Christian Medical College at Vellore, Indian Society of Health Administration (Bangalore) Voluntary Health Services, Adayar, Madras, CHETNA, Ahmedabad, Gandigram Institute of Health and Family Welfare, Dindigul Anna Dist, Apollo hospitals, Madras, Arma hospital, Madras have participated by presenting papers, deputing participants or by presenting in poster sessions.

The proceedings of the conference were arranged as planery sessions, parallel presentation discussion sessions, poster presentation, exhibition of Media publications, slide shows, Film projections. Exhibition of media hardware was also arranged.

Field visit was also a part of the conference. Participants had a choice to visit any of the following field program on one afternoon session.

1. To Centre for Health Education and Development Injampakkam, off Madras.

2. To Pettai Village of Institute of Public Health, Poonamallee.



### 3. EMMA Communication (Health Education Media Preparation Center) Madras.

The participants were taken in the vans allotted for each of the study areas, with a guide and brought back. The participants apart from their discussions with the local people and program personnel shared their experience with others in a plenary after their field visit.

The 3rd regional conference of IUHPE at Madras organised by TAMSEARB SEARB had the benefit of the participation of the president of IUHPE Dr. MATTI RAJALA who arrived one day before the conference and took active part in finalising the next 3 days programme, and in conducting the 3 days proceedings. His valuable guidance, support and presence contributed much to the success of the conference.

This 3<sup>rd</sup> regional conference had the benefit of distinguished participation from other regional bureaux esp of Europe (Mr. HAGENDOORN) and from Australia (Dr. COLIN L. YARHAM) and Dr. Paul Hindson. It is relevant to add that Dr. Paul Hindson had attended our previous conference at Madras. Dr. Eric De Winter DANIDA Advisor at Madras took an active part on all the 3 days and contributed much in each of the sessions he attended.

This conference was supported financially by DANIDA and UNICEF apart from the resources of SEARB. The WHO-SEARO extended its support by deputing Dr. Soraj. S. Jha, its advisor who actively participated in the technical discussions, both formally and informally.

The proceedings of the Inaugural (See Page : 358 - 373), Validictory sessions (See Page : 380 - 393) are given seperately and the recommendations are given on page 374 - 379)

Message of good wishes for the success of the conference has been received from many dignitaries including from His Excellency The Governor of Tamil Nadu, Minister for Health Family Welfare, Govt of India. Minister for Health, Government of Tamilnadu, Minister for Social Welfare, Government of Tamil Nadu, Secretary, Ministry of Health Family Welfare, Government of India, special secretary to Government of Tamil Nadu in Health Family Welfare department, Secretary government of Tamil Nadu in Education, Science and Technology department, Secretary to Government of Tamil Nadu in Municipal administration and water supply departments.



## **References :**

1. Proceedings of the first South East Regional Conference of IUPHE (Education for better health of Mother and Child in Primary Health Care) 1986 (Page 615)
2. Bulletin of 3rd regional conference of SEARB of IUHPE (1994) (4 Sections, 333 Pages)
3. Souvenir of 3rd regional conference of SEARB of IUHPE 1994 (5th Section 260 Pages)

## **Appendix 1**

### **Conference Sub Committees**

#### **I. ORGANISING COMMITTEE**

Fr. Emmanuel Mariam Pillai (Chair Person)  
Dr. K.V. Shantha  
Dr. A. Parthasarthy  
Dr. Sumathy S. Rao  
Mrs.K. Shanthi

#### **II. SCIENTIFIC COMMITTEE**

Dr. K.A. Pisharoti (Chair Person)  
Dr. N.C. Appavoo  
Dr. V. Kapali  
Dr. V. Natarajan

#### **III. EXHIBITION COMMITTEE**

Mr. G. Kittoo Rao (Chair Person)  
Dr. V. Prithivi (Chair Person from Dec. 1993)  
Mr. Ramanathan  
Dr. H. Pramila  
Mrs. Sarojini  
Dr. Murugesan  
Mrs. Annie Valsarajan  
Mr. Tharani Singh

#### **IV. FINANCE COMMITTEE**

Dr. N.C. Appavoo (Chair Person)  
Dr. H. Pramila (Treasurer)  
Dr. Paul Kandaswamy  
Dr. Padmanabhan  
Dr. G. Palani  
Dr. K. Rajendran



# INAUGURAL SESSION SPEECHES

**Dr. A. RAMALINGEISWARA RAO**  
**(President, TAMSEARB)**

As President of the Tamil Nadu chapter of SEARB for IUHPE it is my duty to extend a warm welcome to the city of Madras especially to all International participants who are present here. It is my pleasant duty to welcome you all to this important conference dedicated with the important issue of problem of Peoples Involvement in Health and Development of Women and Children.

I extend my welcome to all our colleagues from the Sister chapters of Andhra Pradesh, Karnataka, Kerala, Punjab and other chapters in Nepal, Bangladesh.

I feel it is appropriate that we have chosen a topic here at an appropriate time so that the experiences of all of us in regard to this particular field can be analysed, assessed especially the Peoples involvement in management of health as well as the priorities of importance given by people.

The Details of the choice of the topic and the objectives of the conference will be shortly spelt out by Dr. K.A. Pisharoti.

We have chosen specially Mrs. Gariyali for the inaugural session because of her deep involvement in the development of health consciousness of people, and health services in the State as a Collector, as Director of Family Welfare, as Special Secretary to Government of Tamil Nadu.

I request Dr. Matti Rajala the President of IUHPE to take over the session and conduct the proceedings.



## **Dr. MATTI RAJALA**

It is my pleasure to invite Dr. Pisharoti to address this session.

## **Dr. K.A. PISHAROTI: (Chairman, Scientific Committee, 3rd Regional Conference of SEARB)**

I will talk on the genesis and objectives of this conference.

The concept of Community participation is centuries old as far as India is concerned it is practiced by village communities in organising village festivals etc. Its application to the Health field is very recent.

The concept of Community participation in Health was first promoted in early 1920's under the Rockefeller foundations experimental project of improving environmental sanitation in Indian villages. Later Bhore Committee in 1940's suggested formation of village health committee and involvement in implementation of Health programmes. The idea of formation of Village Health committees further got a boost after the formation of Community Development Blocks and establishment of PHCs. Further impetus was when National Family Planning Programme was implemented when Block Extension Educator (BEE) was appointed as part of the organisation of National Family Planning Programme. The climax was in the Alma-Ata declaration which recognised community participation as one of foundation pillars of Public Health Care. In spite of the above best intentions and efforts on the part of Governmental and non - Governmental agencies to translate this concept into practice, not much of success has been achieved. Meanwhile lots of other development have occurred. There has been an increased recognition that Health Education shall play an active advisory role which they have been shunning away in the past to promote health. The concept of involvement of people to take responsibility and decision making and action program is another. The change in the definition of Health Education itself incorporating social action as part of it is still another. That many sectors other than Health can influence Health, both positively and negatively provide another opportunity. All this led slowly to coordinated action by all segments of people and by Government and non Government agencies. It is these developments that influences the title of the conference as peoples involvement. Can we provide some reasonable answers to Health providers, administrators who have been asking the question, "What is Community involvement in Health. Please give some guidelines as how to translate this process into action." I feel we shall try to provide the answers in the 3 days conference.



To achieve this we may have to concentrate on some broad areas which if implemented will help us to achieve the overall objective.

Since women and child health constitute more than 80% of the nation's health problems it was thought that Peoples involvement in programmes aimed at development of Women and Child Health and their status is appropriate.

There have been number of experiences among workers and scholars in this field, both in the country and elsewhere in the globe, that village people, though illiterate, can understand and participate in their Health development by contributing by taking individual decisions on Health matters. Some of the experiments related to involvement of people are the use of locally recruited village volunteers to act as interface between Health providers and consumers of local groups and train them to take active role in Health promotion: involvement of schools in community health promotion; involvement of women primarily as change agents, not mere recipients of Health service; enlisting political support to health, training health care providers with knowledge and attitude to promote community participation, use of media both cultural and electronic to provide and promote community involvement in health; on improvements made in the institutional mechanism for community involvement.

It is the implementation of many of these largely successful experiments that influenced to organise this conference. There are many who can share their experiences to those who are not so familiar with such experiments but who want to know what has been happening around. To bridge this gap in knowledge between the participants will be one of the functions of this conference.

1. What do we mean by peoples' involvement, why is it necessary, what is the rationale behind it.
2. What are the major barriers, social, political, economic, institutional to promote peoples' involvement in health, how obstacles have been overcome. Large number of studies have been done on this, and how some of the obstacles have been overcome. Lessons learnt from these studies, both success stories and not so successful stories, how can they be applied in a state or national problem.



3. How to utilise these to make institutions and the Health care providers more responsive to meet the needs of people in involving them in their health development. There is quite a lot of criticism that health care providers have probably not have adequate knowledge or attitude to promote community involvement in health. How can they be trained, what structural changes are required. Some studies presented throw light on these areas.
4. How can the media both cultural and electronic be utilised to promote community involvement.
5. Practical guidelines in behavioral concept of peoples involvement for more successful implementation of programmes like Child Survival & Safe Motherhood (CSSM), AIDS, Family Welfare Programme.

We have administrators, academicians, practitioners, research persons in this assembly. We can put our combined efforts to get some solutions to help administrators in promoting community involvement of people in Health Department.

**Dr. V.R. RAMAKRISHNA**  
**(Regional Director, SEARB, IUHPE.)**

First of all I want to say that woman's power, though we accept it traditionally in a traditional society, we want this power, this sakthi, to dominate and see that this deliberation succeeds. In our traditional society though we raise the women to high pedestal as Goddess like Saraswathi, Lakshmi, Adisakthi, yet when the distribution of food comes, they are the last to receive food (Laughter). This is in our traditional society. I invoke the Adisakthi today to give necessary energy, knowledge to everyone over here so towards the end of the conference we go hand in hand so that we work with women towards Development of not only India but the South East Asia Region.

The first conference was on Women and Children. 2nd conference also was on Women and Children. This conference also focuses on Women and Children. Why? I feel that as we all say, We educate the Mother, we educate the family; if we have educated them, i.e., half the section of the population, we have educated the entire population. But we have neglected this so long. Women continue to be neglected. They are not approached and educated and empowered. Lip sympathy only is paid. This conference must be dominated by women. This



conference must gain through the involvement of women activists. In the 3 days let us share our experiences and churn it so whatever nector comes out of it, let that be guidelines for our actions.

It may be only a few points, yet they will be valuable from implementation point of view. What is people involvement? Who are the people? As Women & Children are 70% Please concentrate on women, though Peoples' involvement is stated. How do we involve women to better their health, to better their position, their status. How do you use or empower women. This is the most important concept of people as far as this conference is concerned. So I would request you all to focus alongwith people involvement, on women and children. How to convey, encourage and involve women so that they can take care of their own health and disseminate that health to entire family and to the entire community. That is what is required for people especially the women in rural areas, women not educated, women who have no sustenance, they do not get 2nd meal in the day, women who receive all Antenatal care and advice but who says what to do with this advice when I have nothing to eat, after serving my children and husband. How can we involve that lady in our endeavour to promote peoples participation, to have better nutrition for her, for her children, for her entire family.

You might have read in Newspapers recently in Nellore District the demonstration of what womens power is. The Government has been forced by them to introduce abolition of all liquor in that district. Mr President, Rajala, this can happen. It has happened in Andhra Pradesh, Nellore District. If women power is aroused and supported, I am sure that women of a district can give a lead to women of that State and other States in India and World.

Similarly in 2 villages in Karnataka, Women with the support of their IAS Officer, like you, Madam Gariyali, has abolished prostitution, by their own efforts. The traditional prostitution practiced by some women in their villages was abolished.

We want total involvement of people, of women in their own development, economic and health. involvement is much more than participation. It is material involvement, social involvement, mental involvement. Unless you are mentally involved, you can not achieve anything. There is also spiritual involvement. Involvement shall also be looked into in terms of physical involvement which includes financial involvement. But just financial involvements, just giving Rs.100/- to this



conference, and say "I am happy to be" involved "in this conference." But that is not real involvement to me. But I am mentally involved, socially involved. With this full involvement, all shall contribute to this conference.

The objectives of this conference have been just listed by Dr. Pisharoti. They have been printed in the back ground documents produced for this conference. Kindly look into them. You can look into it, you can add to it, change it, reinforce it. By the end of this conference, can we go with certain practical knowledge principles and guidelines which can help to involve women in their own development and own well being and that of their family.

**Dr. SRILATHA : (UNICEF, Madras)**

On behalf of UNICEF, I am happy to say that UNICEF is happy to sponsor this conference, because the goals and objectives of this conference are very much close to the goals of UNICEF. The UNICEF is mainly for women and children and UNICEF mandate includes supporting Government delivering structures and empowerment of women so that Health of children are taken care of.

We look forward to many occasions during this 3 day for interacting with you with many suggestions and concrete proposals.

UNICEF concerns in People's empowerment. Firstly at individual level of a person, or mother. Within the context and the goals of CSSM, we have a set of very clear and concrete goals. Within the context of these goals, what are individuals expected to do. These have been stated in the booklet FACTS FOR LIFE, which I hope everyone here is familiar with. To make every mother, father know the contents of Facts for Life itself is a mammoth task. Because the existing systems of health, nutrition and other infrastructure that we have do not yet reach out every individual in an intensive way for them to learn and internalise these concepts. If you are able to achieve this, that is a very big achievement. We have to be conscious that time is running out. We have urgency. We have many times discussed, experimented in the area of community participation far long enough. Now the time has come for actions. We all have to go out and do something about it. May be we have to reach out every person, may be we need volunteers on a mass level. How can we reach out to every Mother and Father and with the information on FACTS FOR LIFE. To community level, how do we ensure that goals that have been set by Heads of Nations are



known ? Government of India has acted on this. The Government of Tamil Nadu has acted quite fast on this. Other society agencies, the private sector in health, the teacher, all other local bodies, the society and community at every level are to be aware of these goals. What are we moving towards? What is it that we want to achieve in Health?

At every level these societies and communities and agencies need to be aware and have ownership of these goals. Then only we can achieve these goals. So we do have to do things on a large scale, and do that very fast so that we can move towards brighter goals.

I hope each one of you will give good ideas and suggestions to achieve our goals.

**Dr. ERICK DE WINTER : (Health Consultant, DANIDA, Madras)**

Peoples Involvement in Health and development of Women and Children is the topic of this conference. The choice no doubt comes from the present picture of health of women and children and health education is only partially successful and something needs to be done to improve its effectiveness and success of health education program. It is to say that people at present are not totally involved, not involved in planning and also not involved in implementation. In these, they are not involved as much as we think they shall be involved, in terms of planning, in terms of needs assessment, priority, determine goals; the people themselves are not frequently involved in determining what the goals of health education planning shall be, in determining what kind of strategy is to be followed in health education. People accept the program as some sort of recipient of services which is sprinkled over the society. This is very much, you know, is the traditional situation, in many parts of the World.

We feel we want to see change, change in its political sense, in decentralising decision making away from central levels in a climate of economic liberalisation. It all amounts to more concentration on what consumer wants. So this is a timely subject to talk about peoples' involvement. In discussing what their problems are, or as they perceive to make the people aware of their problems, where the problem exists, or continues to exist, whether the problem is eliminated, to make people concerned when the problems continue, to make people motivated to do something towards these problems, and to provide technical knowledge to do something about it. This is, I think, involve



people when you educate the people, community . This conference is to educate the educators, health educators, to make health educators aware of the problem i.e., aware of the problem that health services are frequently ignoring people, and are in many cases provider centered.

This means, making Health Educators concerned about this problem unless we do something towards this, the neglect of involving people will continue in that way.

To make health education motivators to do something about it i.e. involving the people, I am sure that this conference will succeed in providing technical knowledge to health educators in terms of means that can be applied to community involvement.

As far as DANIDA is concerned this is a very useful and very timely conference. So I am glad that DANIDA has agreed to give a substantial financial help to this conference.

I am sure that this will be a very successful conference.

### **Dr. SHRESTA : (Vice President SEARB, IUHPE)**

We are encouraged that Dr. Rajala could be with us, also HANS Dr. Collins, Dr. Jha of SEARB, Dr. Srilatha from UNICEF, Madras.

SEARB is 10 years old now. Despite paucity of funds, its achievements has been very creditable, mainly because the bureau has the services of a highly dedicated person of Dr. V. Ramakrishna and other dedicated professionals in different capacities. Within this decade 6 state level chapters have been set up in India, and national level Associations in Bangladesh, Nepal, Srilanka and Thailand as a result of SEARB's initiatives and efforts.

During this decade conferences were held one at Madras and another at Bangalore and this time another conference is being held again at Madras.

SEARB has conducted several training programmes, seminars, research studies, evaluation studies, media programmes. It has been publishing its bulletin now titled HEALTH EDUCATION IN SOUTH EAST ASIA, a standard Health Education Magazine in this region.

All the countries of this region appear to have given importance and priority to health education but really it is not so. Without adequate support in terms of budget and manpower and other support, desired level of health education services can not be achieved.



Nepal is one of the least developed countries in the world and its topography and geography is mainly unfavourable as well. Recently the Health Education set up in Nepal has been reorganised and it has found a very high place in the hierarchy of Nepal's Health system. The Health Education Association of Nepal, with the coordination of Health Education cell of Nepal Government has organised Health Education activities in the flood affected areas and on Health Education Day on 14th March every year. In addition the association has participated in several Health Education campaigns of NEPAL. There are 2 Lady Health Officers from Nepal attending this conference.

We are thankful to Tamil Nadu Health Officials and Tamil Nadu Government to have hosted this conference in Madras.

The theme of the conference is also appropriate and timely. Women constitute a very vulnerable segment of our population in the region. They are deprived. Let us, in this conference, evolve strategies to involve people in the promotion of development of Health of women and children.

## **MR. HANS HAGENDOORN**

**(Vice President, European region of IUHPE)**

It is a honour and sincere pleasure for me to be here in this conference as Vice President of Europe region of IUHPE. I congratulate the organisers for having brought so many people here for this conference from all over India and abroad here in Madras. I am sure that this conference will bring and generate new ideas, contacts, friendships, issues and bring out the common scenarios, customs and habits. This will benefit us all. The theme of this conference is well chosen. The theme is very important for the whole world. In these conferences the torch, which is depicted in the logo of the organisation, is passed from those who are experienced or rather more experienced to those who are less experienced or starting. Also in the logo, you see the torch is burning and in the background is the world. It depicts Health promotion and health education globally. Indeed we are learning from colleagues, new approaches, failures and successes. We can learn from each other and the torch will burn brightly. The Union has a new logo, just a few weeks ago, and it holds people hand to hand. This shows the cooperation and sharing and handing over. In these conferences the torch is passed on, and also unity is maintained. In this respect the union is really an international movement.



Health Education and Health promotion and the role of Public Health are possibilities to strengthen community and in the end improve public situation.

The South East Asia region of the IUHPE is one of the most active regions of IUHPE of the World. For this I want to congratulate Dr. Ramakrishna and his collaborators for their outstanding contribution in inviting so many professionals in the region and showing great result. May this be example for rest of the world. I do hope that we can find possibilities within the context of IUHPE, to come up with many projects. There is so much experience here and abroad in Europe and other places that it must be possible to build up some strategy in practical cooperation.

I wish you all success.

**Mr. COLLINS YARHAM**

**(Consultant in Health Education and Promotion, Australia)**

It is great pleasure to attend this conference. I bring greetings from Australia. I bring greetings as a member of many years of the IUHPE. The union has been honoured by the work of South East Asia Region.

We can learn from one another, learning to help one another. May this cooperation continue. I am very proud to be a Health Educator. It is a honourable profession and honourable task. Please remember that Health Education is not something done to or for some one. It is done with people. If we can learn at this conference, as how to act, how to stimulate people to work together, the word involvement is understood in some regard.

I wish you well in this conference.



**Dr. (Mrs) SORAJ JHA (SEARO, WHO )**

I bring greetings from WHO's South East Asia Regional Office to this conference. The WHO is closely associated with IUHPE, right from its inception and SEARO provide lot of support to the extent possible to SEARB over the years.

The theme of this conference is extremely relevant to the interest of WHO's SEARO. Last year, at the regional committee of SEARO, Community action (CA) for health was the subject for technical discussion.

Community Action for Health is also going to the subject for technical discussion at World Health Assembly next year.

I hope that at the end of the conference, after exchanging experiences, we will be able to put together some ideas and put forth to the Policy makers and decision makers as how to go about this whole question of community involvement and participation in health.

Thank you.



**Dr. M. RAJALA (President, IUHPE)**

Health is our most valuable resource. Individually and collectively we need health not as a thing itself but as a resource for daily living and for pursuing a satisfying, creative and carrying way of life.

Through out the world, Peoples capacity to make healthy choices and a degree of control they have over the conditions which make these choices possible varies widely. Global activity to change this situation requires continued and expanded effort.

All organisations concerned with global health need to asses their current mandates, membership and actions in the light of health challenges which can only increase in the coming years. It is in this spirit that IUHPE will make changes in order to do its part in meeting with challenges.

As a global organisation, the IUHPE has during its 42 years, served as a forum for people organisations, today from more than 80 countries to share knowledge, experience, ideas related to field of Health education.

We are convinced that IUHPE must do more. We are committed to ensuring that IUHPE is on its fine history by responding positively to the broader definition of Health by acting on the contemporary concept of Health promotion and for reaching out to the many sectors and discussions who must work together to achieve Health for all.

We intend to put education into a healthy public policy context and contribute to the development of a global infrastructure which will support health promotion activities and therefore I am most pleased to announce that the general assembly of the IUHPE has voted to change its name to IUHPE, to adopt a new and contemporary image which reflects this change, as described earlier here by Dr. Hagendoorn.

The new name and image is intended to convey this message that the International Union for Health Promotion and Education is both relevant and unique in its capacity to bring people together to work on World Health issues.

It also meant to convey the open and inviting nature of the Union.

I am fully aware that the new name and new image are only first steps. In consultation with our membership as well as people outside of the union, we will be creating a mission, a strategy to take us into the 21st century. These strategies are accepted by a parallel plan to



develop a world wide health promotion and education network. With your support and participation and involvement this network can become a potent and sustained force on the broad scene, capable of major contribution to global health.

We invite you to join us and help shape the future of International Union for Health Promotion and Education (IUHPE)

It is most appropriate indeed how this conference on people involvement in health and development of Women and children provides an opportunity to launch the International Union for Health Promotion and Education. Making people aware of the change is fundamental to health promotion approach, the union wishes to adopt creating opportunities for people to become involved, following sensitization the challenge we are eager to take on.

Thus most appropriately, the theme of this conference is in the very core of our domain.

May I take this opportunity to thank and congratulate the organisers of this conference. I wish to congratulate SEARB, Dr.V. Ramakrishna and Tamil Nadu Chapter of IUHPE, Tamil Nadu Government for their support, UNICEF, DANIDA, WHO for the support and other persons involved in organising this conference. I will also like to thank you for coming and participating in this conference.

The theme of this conference is of utmost importance and challenging. One can only ask if we fail in involving the people, what is left.

Thank you very much. I wish all the best for the conference.

Now, I have great pleasure in calling Mrs. Garyali to give the inaugural address.



**Mrs. GARIYALI. I.A.S (Commissioner and Secretary,  
Tourism Department, Govt of Tamil Nadu)**

It is a matter of great satisfaction for me to be with all of you this morning and participate in his conference which is very dear to my heart because I believe that nothing is possible without peoples participation; particularly in the field of Public Health, Family Welfare, Women and Children, the key factor is peoples involvement and peoples participation. The success of these programmes will entirely depend on masses, groups, communities, identifying them, unless this is done we will not succeed because these programmes concern personal habits of health and hygiene of individuals and groups, these concern with child rearing practices and dietary habits of the people, these impinge upon the related customs and several habits and social cultural practices of the individuals and groups and hence unless individuals and groups are with us we can not succeed in these areas. It is impossible to make inroads in these areas without the involvement of the people. In fact, I consider it entirely wrong to design these programmes for people and thrust on communities. They have to be designed by people themselves and have to be geared to their own requirements. It is very wrong to make these programmes rigid and uniform, these are to be elastic, flexible and need based and differ from man to man, time to time. In the Panchayat Raj system to be ushered in this country, planning could be entrusted to the grass root level and implementation could be decentralised and monetary resources should be entrusted to the people for implementing the programmes. If we are able to achieve this, we have made great strides and improvements in our goals on public health and to women and children.

People are not concerned now because of the feeling that Government functionaries will do.

So, our slogan should be back to people and back to villages.

Tamil Nadu has a long history of successful peoples participation in this state in most of the programmes especially in several of the health and nutrition programmes, in women and children programmes. Some of the notable areas, which I would like to mention because many of you sitting in this hall having been working in some of these programmes in involving people in those programmes. The community constructed structures in some districts like Salem, South Arcot, under DANIDA and thus constructing their own health facilities, functioning of village health committees under many health and nutrition pro-



gramme are some of the successful experiences in people participation; similarly functioning of women's group in the Chief Minister's Nutrition programme has been very successful element in child oriented programmes and nutrition programme. This state of Tamil Nadu is known for involving voluntary agencies primarily interested in health especially Primary Health, Contraceptive programmes, Immunisation, and achieved success because all these agencies or groups or individuals have stood by us in all these things.

We also have been involving individuals and communities in sanitation programs is individual latrine, in village latrine programmes and this has been entirely successful because of the efforts in involving people in these programmes.

Now what shall we do when we come towards 21 century. I am only pointing out 2 or 3 areas on which all our health educators and Health planners can concentrate. One area is we have already introduced National level monitoring in our department both in immunisation programmes and Family Welfare oriented programmes. How we are involving community in these National level monitoring? Will it be possible for us to involve the community in villages in micro level monitoring in all these programmes? I will be very happy if this is tried in projects or in State level projects. Similarly community involvement in micro level monitoring at grass root level.

We have already identified certain resistance areas, the area which are not responding so well to developmental activities for Women and Children, in Health, Family Planning. Is it possible to evolve special programmes for these resistant communities and groups? Is it possible to put extra input in those areas to involve the communities in planning for their services in a different manner, so that if they do not fit in what we are doing every where we have to develop something different or special over there.

We have evolved some programmes like this for Fisherman, for weaving communities and some of the minority communities. This kind of Flexible planning shall be tried at micro level by all of you sitting here.

It has been said here and elsewhere often that unless we empower women, nothing is possible. I can tell you that if we are really going in for this kind of programme of development of Women and children empowerment is necessary. They have to be empowered. It



has to be freedom of mind, body and soul. We must contribute to educational programme of women. We have literacy programmes now for women. We have to tag on health education to this adult literacy programmes. We have to make use of all the volunteers who are doing these campaigns in various villages and town in various district and states. We shall tap the resources of all these volunteers who can carry our messages far and wide. The new challenge is the problem of AIDS. This has to be taken into consideration as a challenge for 21 century for our country, for our state. We have to educate every body, the children, youth, labourers, the women, the villagers, the target group especially. We shall take stock of the position of AIDS in our country and what is the future with regards AIDS in our country and what shall be do towards this.

Recently we have launched a 15 point programme for children. This also is 15 point programme for women because we can not have a programme for children without taking care of the mother. This 15 point programme will be with the health department and public health professionals and health educators can play a great role in implementing this programme, with peoples participation involving voluntary agencies, with public sector undertakings participating.

I urge all of you sitting here, especially those from Tamil Nadu to take up this programme and study it, to implement it successfully for a better future to the people especially women and children.

Thanking you !, I wish this conference Success !

The president Dr. M. Rajala requested Mrs Gariyali to release the conference bulletin and souvenir,

After the release of the bulletin containing the conference papers (recieved sufficiently early to the conference date) and souvenir, inaugural session came to an end with a vote of thanks to invited dignitaries, and to participants by Dr. Sumathy. S. Rao, Secretary of the TAMSEARB, IUHPE.



# RECOMMENDATIONS

1. Since the success of involving people in Health and Development of women and children depends largely on the political will and commitment, the conference *recommends that all steps be taken to educate the political decision makers and enlist their support*. Political commitment will have to be reflected through legitimising such activities in the national/state health service system, decentralisation of responsibility and authority in the health service and establishment of machineries for participatory planning at the district level and below.
2. Recent enactment of legislation by the Central and State Governments provides for a decentralised set up for planning and implementing all developmental activities including health at the grass root level. The set up provides for involvement of people, through their elected representatives for adequate representation of women in planning process, for integrated approach to development and intersectoral coordination. At present, programme activities connected with health and development of women and children are shared by a number of departments who see them in a rather compartmentalised manner. In order to coordinate all these activities for maximum effectiveness and efficiency and provide for convergence of activities, it is recommended that *a separate standing Committee on women and child health and development be set up under the Panchayat raj institutions with responsibility for planning and coordinating all activities. It is also recommended that suitable training programme be organised for members of Standing Committee and other elected representatives to enable them perceive clearly their roles in the programme and adequately perform their tasks. It is equally important that elected male members should be specially oriented to perceive gender specific issues related to women and children and address them in an effective manner.*
3. Within the existing administrative set up, the district provides an ideal location for promoting and supporting peoples involvement in Health and Development. The district is meant to include all health institutions Governmental and voluntary-providing health care to people, and health related sectors. It has a well defined area and population. In order to enable the District Health Services provide the leadership and support for involvement of



people in Health and Development of Women and children, the conference recommends that *the district health system to be so organised to (a) provide for decentralised and mirco-level planning with active involvement of local people (b) have an information system that will provide data not only for planning but also for monitoring progress in implementation (c) Strengthen the capability of district level managers and supervisors for decentralised planning and implementation (d) ensure quality of services within the decentralised set up and (e) strengthen the supervisory support mechanism to improve performance at various levels and also deliver an integrated package of services.*

4. Non-Governmental organisations have generally been found to be very effective in promoting people involvement in health and development. With flexibility in their approach, effective I.E.C. package and starting with felt needs of community, they have succeeded in sensitizing, involving and motivating people to action. The conference therefore recommends that *(a) N.G.O.S be encouraged to be actively involved promoting peoples involvement in health and development of women and children (b) that partnerships be established between governmental agencies and N.G.O.S, with the responsibility of the latter being well defined and (c) government provides administrative, financial and technical support to N.G.O.S, where needed, so as to facilitate their active participation.*
5. In order to make a success of people involvement in health and development of women and children, people themselves will have to be empowered with requisite knowledge, skills and attitudes that will enable them to take responsibility for their own and community health needs. Education is key towards empowerment and the process takes time to succeed. In order to achieve this, the conference recommends that :

i. *Education/Communication strategy provide for*

- (a) *Mass Media programme to provide authoritative information.*
- (b) *Traditional media for a face-to-face transmission of selected and treated educational messages and*
- (c) *Interpersonal change agents to work as on compulsive persuasion.*



- ii. *Training of community leaders, volunteers and representatives of various sections of people in program management skills including enhancement of their leadership skill.*
  - iii. *Paying special attention to reach the not-so-easily approachable (socially, geographically) group of women and children and*
  - iv. *Health care providers to act as facilitators of change and encouraging people to take responsibility in planning, implementing and evaluating programmes for meeting their health and developmental needs.*
6. Experience in India, Bangladesh and other countries have amply demonstrated that women, themselves, can play an active role in promoting their own and their children health and development. It is even stated that when women become leaders of health movement, then People's Health is in Peoples Hands. In order to achieve this, the conference recommends that
- (a) *Women groups be established in villages, urban slums etc., either formal or informal, and such groups encouraged to take responsibility to plan, implement and evaluate health and developmental activities for women and children. Mother's clubs, women Co-operatives are examples of such groups.*
  - (b) *In order to enable such groups function effectively, members should be given adequate training on technical subject areas, programme management and leadership skills development. The initial training should be supplemented by continuing training, depending on needs.*
  - (c) *Women groups should not only be recipients of information and services but also be trained to function as agents of change. In order to raise the status of women and enable them play an active role in decision making within the family and community, they should be trained not only on health and development but also income generating activities. With the skills so acquired, they should be encouraged to earn an income and such women should be given access to credit facilities for starting income generating activities.*



7. Development of human resources is key to promote peoples involvement. Training is needed not only for service providers and their supervisory / Management cadres, but also for community leaders. In order to facilitate this, the conference recommends:
  - (a) *A review of training curricula of categories of personnel to ensure that the concepts and practice of people involvement are adequately covered.*
  - (b) *That the training itself should be action-oriented and designed for development of skills to work with rural/urban communities, social institutions and others.*
  - (c) *Service providers recognise and practice the concept that they are facilitators of change and it is their duty to encourage people to take responsibility for meeting their health needs.*
  - (d) *Training objectives, content, methods and duration to vary according to type of trainees.*
  - (e) *Since adults learn in ways different than that of children, it is essential to keep adult learning principles in mind.*
  - (f) *Integrated, participatory and gender specific approaches should be included in all type of training.*
  - (g) *Stress on Co-ordination, Co-operation and team work among grass root workers, supervisors and managers.*
8. *Since children are found to be (a) good communicators, the conference recommends that children be utilised to pass on information on health and health related subjects to peers, family members and members of community (b) The children should be trained adequately to perform this function, both in formal and informal ways. The teachers should be encouraged to use their innovative talents in developing this capability in their pupils. Approaches like child to child and child centred teaching-learning shall be encouraged in all schools. (c) The teachers should also receive training and be provided with adequate teaching materials.*
9. Recent experiences have shown that participatory approach in information gathering at community level is not only practicable, but also reliable and less costly. It could be done with a little training. In addition, it enhances peoples motivation in planning and implementing health and developmental activities. The conference therefore recommends that :



***People's participation be encouraged and promoted in gathering information at grass root level : such information may relate to data required for planning, information for monitoring progress of implementation ; and evaluation of programme.***

10. Ever since the country achieved independence the role of community participation has been stressed in planning and implementing developmental activities. In spite of this, the progress achieved so far, on a national scale, is less than satisfactory. There are a number of reasons for this, some relating to organisational structures, others to bureaucratic attitudes, some relating to socio-cultural factors, some political, some due to apathy on the part of people and many others. The conference recommends that these ***obstacles to community participation/involvement be studied in depth and actions initiated to remove them to the extent possible.***

At the same time, there have been a number of successful experiments carried out in India and abroad, particularly in Indonesia and Bangladesh on people's involvement in health. Very useful lessons have emerged out of these studies. ***The conference recommends that these successful experiments be studied in depth and lessons learnt be distilled out for their possible adaptation, both at local and national level, and within the country.***

The conference further recommends that :

***SEARB can effectively undertake both the above activities. In addition SEARB could perform an Advocacy role to influence political decision makers and programme planners to incorporate people's involvement in planning health and development programme for women and children.***

12. Based on experiences gained so far in people's involvement, the conference recommends that
  - a) ***Highly committed and motivated workers be selected and placed at various levels - national to periphery - to make people involvement a success.***
  - b) ***Ensure continuity of leadership at these levels so that the staff will have adequate time to plan and implement such activities. Management by objectives will help build involvement and commitment.***



13. It is widely accepted now that health is the result of a number of variables, apart from the usually recognised biological factors, a number of others like social, political, economical, environmental, life styles etc., interact with the biological factors and affect health. Therefore a number of health related sectors have a role to play in promoting health and development. Therefore the conference *recommends* that :

*Health sector, in coordination and cooperation with other health related sectors mount a joint approach to promote health and development of women and children. Such a joint approach is more likely to be acceptable to local population. The question of bringing about co-ordinated efforts is a challenging task which has to be faced. The staff of health related agencies need to be adequately trained so that they too appreciate the need for joint efforts and lend their helping hands to such a joint endeavour.*



# VALEDICTORY SESSION SPEECHES

Dr. A. Ramalingeishwara Rao Welcomes the dignitaries for the Valedictory program.

Sri Kirubakaran, IAS Presides.

**Dr. M. RAJALA** (as a participant) :

It has been a great pleasure indeed. I have been given ample time and opportunities to speak in this conference, which I am very grateful for, which I hope, has to some extent of use to other fellow participants. The IUHPE stands for bringing people together for life, for health, for caring for peoples health.

This conference has been an outstanding example of dedication and high quality of Health Education and Health promotion of the community in this region. It was organised in an outstanding way. We can take much back home that we have learnt in these days both organisationally and from scientific point of view. For me personally this has been a great opportunity because this is my first visit to your beautiful country. Some people have said to me that my name sounds Indian, which is flattering of course. But also appropriate because I know that I happen to have a tiny drop of Indian blood in my viens. I said before that I will leave a part of my heart behind me and I am very serious in saying that with an hope I will be able to return to this country next time with a strong feeling of coming to a country where I have friends. Thank you very much.

(Dr. Matti Rajala is the President of IUHPE. He is from Finland)



**Dr. SAROJ JHA :**

In 1978, the Alma Atta declaration affirmed that participating in Health is not only peoples' right, but also is peoples' duty. And ever since then we have been talking about the community participation, community involvement in health. But this was one of the rare occasions, participating in this conference, that one came very close to actually hearing about experiences which demonstrated community action in health and it was extremely enriching for me to hear from various levels of Health workers and Health educators, their experiences, their innovations in work in their project and program areas, particularly related to health of woman and children. I go away from this conference feeling elated, very enriched, and I am sure that in the next few years we are really going to see not only the status of health education improving tremendously in this country, but also more and more experiments which will show that community participation is possible. We have a number of recommendations made. I think some of the recommendations may take years to implement but there are several recommendations that we can implement ourselves straight away and one such is related to training. I am sure all of us here, in our various training programs can implement this recommendation most; straight away, without waiting for political commitment, coordinating mechanisms, standing committees, panchayat rule; we can implement straight away this recommendation, we may introduce participatory forms of communication in our training for innovative ways of informing and educating people and generally promoting peoples' involvement in health.

Thank You,

(Dr. Saroj Jha is advisor, Health Education, SEARO, WHO, Delhi)

**Ms. KHIN SANDI LWIN (UNICEF Representative at Madras)**

I am sorry to have missed the conference unfortunately. I had to go to Delhi for the past 3 days. But learning from the recommendations, resolutions, I can see also from the very thick bulletin. I can see all the things you have been discussing are critical in what you are trying to do in terms of achieving the world summit's goals for Child Survival and Development and in Tamil Nadu, I am sure that Mr. Antony and Mr. Kirubakaran will be speaking more in detail about the efforts here



in preparing a state plan of action and going a step further, in having a chief minister commit herself to a 15 point programme for child welfare which contains all the elements of your resolutions and which I hope every state in India will follow suite.

Listening to decentralised local management, optimum coverage area, integrated package, panchayat raj, need for information, invoking community from planning to implementation, these are all in the state plan of action.

I am very proud to be part of these efforts. I hope you will go back to your respective states and your countries and if you have not done so to prepare local plans of actions to plan the strategy to achieve the goals that are laudable for this century.

Thank You.

**Dr. ERIC DE WINTER**

**(Health Consultant, DANIDA, Health Care Project, Madras)**

At the beginning of the conference I mentioned my expectations out of this conference. If I start again from where I left 2 days ago, I can conclude that this conference has certainly made us all aware of the problems in involving the community, in involving the people, in development of health for women and children.

I can also say that it is an issue that we are all very much concerned about. Everybody has realised that insufficient involvement of the people will not result in proper objectives being achieved by our activities. It has also motivated everybody who listened to various presentations to do something about it. Finally the last point of my expectations mentioned two days ago, I think the many papers presented, many people talking in the corridors have provided us the thought as to how to tackle the various problems. It does not mean that all problems have been solved but it does mean we have learnt about ways of involving people and those who have not done so until now can do benefit from whatever they picked up from this conference. This conference has come up with number of suggestions, number of resolutions, as just they have been read to you; they will be presented to Government and they may lead to certain structural improvements. At the same time, I would say it is fit enough to go ahead in our own field, in our own way to do something towards involving people in health programmes. We do not have to wait for the government to take decisions and to introduce new ways running state health services. We



have learnt enough to go in ahead to try again for sometime and than meet again at the next conference, exchange views and tell what you have done on the information you have picked in this conference.

As one of the participants, as participant representing DANIDA, I can certainly say, that the money spent supporting this workshop has been money very well spent. I am very grateful having had this opportunity to attend this conference. Thank you very much.

**Sri. BAJAJ I.A.S. (Project Coordinator, TINP, Madras,)**

I want to congratulate Dr. Ramalingeiswara Rao and organisers of this conference. It has been really a great privilege for us to have such a conference in our state. Lot of work has been done. It is now upto us to follow it up with real action in the field.

I wish you all the best.

Thank you

**Dr. V. RAMAKRISHNA**

**(Regional Director, SEARB, at Bangalore, India)**

We enjoyed and learnt quiet a lot during the 3 days. We are going to implement as much as possible within our resources some of the resolutions made, especially what Saroj Jha said about integrating training and other activities, which will improve community participation, especially women and children.

Thank you.

**SRI KIRUBAKARAN I.A.S.**

**(Commisioner, Secretary, Social Welfare Dept, Tamil Nadu)**

I congratulate all the participants who have come up with a good set of recommendations. As usual the Social Welfare Department, Social Welfare Board and Voluntary Agencies will all have a role as a nodal department in bringing all the concerned departments together in pursuing the implementation of these recommendations.

In the matter of communication and reaching out people, I have not found in any source better examples and stories than what Mr. Antony used to tell us. Most of us may be familiar with those stories. But I used to make some of my own wicked modifications to these



stories. For instance in the last meeting we had in the nutrition project, he mentioned how Kerala is head over shoulders over all other States of India in many of the parameters such as health status, healthy children, healthy women etc. He said probably it is because the Maharajas paid attention to these matters unlike Maharajas elsewhere who were busy with harems, concubines and all these, and he used to add a small remark; that is, because they were over 60 when they became Maharajas. In my own version I change that and I say not because of, but inspite of they being over 60. That was the wicked modification I will make. This wicked modification is because of a bit of news which, I think will become a reality the world over shortly. I read in recent issue of TIME MAGAZINE, in most of the Western countries there is a move to push the responsibilities of child bearing and rearing till after retirement because we are busy with a rat race. Mr. Antony will be most delighted that in the Family Planning programme we are in the process of legislation and campaign to delay the age of marriage. If it can be delayed till retirement age, I suppose Mr. Antony's dream would have been totally fulfilled. We are working on this possible delay of marriage, as much as possible.

The other point, after going through your souvenir I saw you had great deal of discussion on technology of health delivery and health care. I do not know whether some of your papers have covered the genetic aspect. As one who had been dabbling with as a student of futurology my own feeling is that by the end of this century DNA bits will be used not only for prevention but even in treatment and it would be the cheapest form of total health care delivery. So I suppose that something from the field of genetics is round the corner which would probably make all our efforts extremely simpler, and that is an area which attracts me, because we are leading in that field. Genetics is one area where not high kind of equipment are needed and India is really doing well. But I do not know whether that was discussed in the papers.

There was a mention of the empowerment of women. As the department mainly concerned, we are seriously working on the empowerment of women and proof of our sincerity is we are holding an international conference of this very subject on 9th March, with Mother Theresa and luminaries from all over the world participating alongwith the Chief Minister of Tamil Nadu and I am sure that some of you particularly ladies here will be participating. Sandi Lwin was kind enough to mention that we are the first State in India to produce the State Plan of Action for child welfare in line with the national plan of



action and it is largely based on community participation; if you really sit down and look at the amounts involved to realise all the goals in the 15 points programme, we will go crazy. So we will have to talk every day about large scale community participation and public involvement and voluntary organisations and as Bajaj mentioned we are doing fairly well in this area. Tamil Nadu has probably the best network of voluntary organisations and their general standard and efficiency is probably the highest in the country and therefore we can look forward to high success in this community participation. We are following this with the preparation of District Plans in the districts so there will be series of meetings taken by the district collectors, with Mr. Antony himself participating and finally the point on which I pin my hope that your recommendations will definitely be followed up in the state and all the Departments will be brought together into harmonious working. It is based on this hope when I expressed when Honorable Chief Minister herself took a review of every department, department by department - Our Department came for review about 3 days ago. She asked "What have you done on 15 point programme, I announced on 11th November 1993, what is the follow up". Ofcourse, I mentioned humbly that every Department has been conducting seminars to link up with this programme, but our most important step is we have been able to get Mr. Antony as coordinator and now I can say with confidence that this programme will get through. It is fitting that he himself is present today here, to tie up all these things together. We all work, all the sister departments in this State, in an atmosphere of no tension and a fairly relaxed confidence that the goals of this program will be realised because Mr. Antony is with us.

With this, I request him to deliver the Valedictory address.

**Sri. T.V. ANTONY. I.A.S. (Retired Chief Secretary, Tamil Nadu)**

I am happy that this particular conference rather the valedictory function has begun absolutely on time, and look like finishing even before time. Normally in a function in Tamil Nadu it is customary to refer to all the 12 people on the dias before the speaker starts speaking. So 12 people start referring to the 12 people on the dias, I was more or less estimating that itself will take one hour, so I need to come to the podium at 7p.m. I am happy that Dr. Ramalingeswara Rao has arranged that at this meeting only the name of the President is to be mentioned before the speaker starts. I sincerely hope that this practice will be copied because all the time everybody is referring to everybody else and what is most vital is that one finds that his name has been omitted and that creates lot of problems!



This subject you are having community health, community participation etc., frankly I can not confess to be an expert and that too talking to experts here. I will hesitate to give any long valedictory lecture on what should be done. However, I would only like to mention what should not be done and what is commonly taking place particularly among administrators of the type I was.

What is our concept of health, particularly in Government. Health even till very recently, in the higher echelons of Government where planning, budgetary allocations was taking place, most of the time, we thought of health as constructing hospital buildings, establishing intensive care units, putting scanning equipments, all types of very very costly things. These represented to most of us health programmes. Even now if you look through reviews of Health in Governmental documents you find more pride is given to the fact that many big institutions costing crores of rupees for curing disease has been set up rather than for measures towards preventing disease or even better promoting health. This concept of promoting health is usually given in my opinion least priority to the extent if you take the health hierarchy who is the one who gets maximum attention. The Heart Specialist, the Diabetiologist, the person who deals with all types of rich man's diseases, they are the top on the wing. They get all VIP visits, all foreign visits of all foreign dignitaries visiting India; They get all the degrees under the sun. Next category are those dealing with prevention of health that is the preventive health people who deal with Malaria, Mosquitoes, water supply, improving water supply, providing proper drainage, sanitation etc. He is not as high as one dealing with heart problems and so not dealing with VIP.

For 3rd category, I can only tell a story. Long while ago, that is about 25 years ago, I ran a very successful Family Planning programme in Tamil Nadu in Tanjore District where as a consequence of what can be called as a synergy or convergence of communication of provision of services, and other things we organised a mass camp 25 years ago, where something like 25000 people got sterilised. The success was largely due to a doctor, the District Officer of the Family Planning programme was the one who ran this programme so well. Thanks to him, I got the credit and very soon the Tanjore pattern became a model to be copied all over India. So inturn I sent for him and said Doctor you have done such a good job for the prestigious project, so what can I do, to reward you? Do you know the reward he asked me? "Sir, get me out of Family Planning" (Laughter). This is the



reward he wanted. Now you understand the priority of orders in our concept for what is important. What is important is things like scans, ultrasounds etc. To my mind, I am saying this at the end of 60 years, what seems to be probably more important is things like cutting nails and ensuring your cleanliness and taking a run and something like cycling, exercise etc. All these things are perhaps much better cultivable than putting crores of rupees onto the other projects. Who will bother about such simple things. Matter of fact about 10 years ago, there was one Dr. Sankaran, who was DGHS and he had the peculiar habit of cycling. When I came to Madras, I was Additional Chief Secretary, I also used to do cycling. It so happened that somewhere in Tirunelveli, I fell off the cycle and had a broken hand, and that evening newspapers reported that the Additional Chief Secretary fell off the cycle and broken his hand. In Tamil Nadu it hit the headlines in newspapers. Next morning the editor of a particular paper rang me and enquired about the fall. I said 'Yes'. He had a request to me. Next time when the Additional Chief Secretary falls off and breaks his hand etc., let it be from a more dignified place like a bus or a car or even a plane, whoever has heard an Additional Chief Secretary falling off a cycle and breaking his hand? Very very undignified. I can not even explain to the public. They thought it is something like a misreporting. I am now answering a spate of letters, that you really fell off a cycle". There are the priorities!

Let me explain the other funny things we do. In Tamil Nadu the South Indian Diet to my mind is a very very healthy diet. How do we begin an average South Indian Meal? Rice and Sambar which contains enough proteins in the absence of meat and other non-vegetable, we take rice and rasam which enable you to consume enough rice and enough carbohydrates, the sweet is the third item and followed by Rice and Curds and lastly a beeda which is the digestive. We have absorbed number of western customs. We think the west only can teach us the best, and so we go to our five star hotels, we go in the order soup, sidedish etc etc. in the order and finally comes the pudding a sweet. It contains chocolate sometimes, which is very sticky and it sticks to your mouth, you will gradually start losing your teeth. If you want to wash your hand which you need to do and in our country there is no need to use fork and spoon because water is good. In their country water is cold and in cold days you could not gargle because the water was very very cold. You can not wash your hand and therefore they used a fork and a knife. Here in India, where water coming from the tap is hot or hotter, why have we gone in for the habit of Fork and Spoon



and not washing hands and mouth. When you do not wash your mouth after a meal and sticky articles like chocolate stick in your mouth and gradually you will need as many dentists as you loose your teeth. Of course, there is employment for dentists also. Don't you think that it is rather silly? The west need the fork and spoon custom. But in our country we do not need these customs. We follow the western customs without understanding and we loose our teeth and we employ dentists and complain of teeth failure. I can assure you about 20 years ago, I went to a Dentist in Belgium and I was then about 40. She looked at my teeth and I had all 32 of them, and she said "my God, you got all your teeth". I said that in India one thing we have, we die with our teeth on (Laughter) Whatever else we do. I do not want such customs which are not ours and which we do not need. This again is a type of health habit which is to be examined. Why are we doing these silly things.

Similarly let us talk of some other thing which we should be doing. We talk of maternal health, we talk of family planning. I must now move to my favourite subject, Family Planning. Because for the last 25 years, I did push family planning. My initials are T.V. Antony. It stands for Verghese Antony but some of my colleagues in Family Planning Department go to the extent of calling me as Tubectomy Vasectomy Antony (Laughter) because for quiet some time I did push Family Planning Programme thinking that the ultimate answer to the population problem of India is just sterilisation or I.U.D. or something like that. It look me a good 20 years to discover that this is only one of several things to be done. There is a program for spacing, etc etc. By now we have committed so many mistakes. I must tell you one mistake. What in our mind is our understanding of the word Family Planning. I got a driver. He had 9 children or so. As soon as I joined in the Department in Delhi. He joined me and I asked him how many children he has. He promptly said, he ofcourse knew my temperament, I have 9 children, but now I have done Family Planning. Now what do you understand this. 9 children and he has done Family Planning. It means that over 40 years our contribution to the Family Planning programme is that we have made Family Planning synonymous with contraceptive. That is whenever we think of Family Planning, we think only of contraceptive. We must understand, what is the image of this contraceptive has in our mind? Contraceptive consists of 3 or 4 well known methods available in India. One is NIRODH or the barrier. 2 is IUD and 3 is oral pills and 4 is sterilisation. Administrators like myself to estimate the success of family Planning Programme instead of measuring it in terms of the actual reduction of Birth Rate, on Fertility or total fertility, everybody



said that it is too complicated for village officers to calculate, therefore let us go by number of sterilisations and equivalence and so what we did was one sterilisation equals one case, 4 IUDs is equivalent to one sterilisation, etc etc. Some mathematical calculations. So we said so much contraception and so much success in Family Planning Programme. That is contraception is equalised to Family Planning. The other day I was at a meeting in Delhi, Central Council of Health and Family Planning, Number of Honorable Ministers of Health got up and said "Sir our target of Family Planning has been achieved". Six of them got up and said the same thing. I must mention my regard is for one Minister who said "Sir, target achieved, but our Birth Rate is still as high as ever". Now is the trouble. Trouble is they have gone on pushing up figures, 60% achieved, 70% achieved, 90% achieved but we have forgotten to look at the essentials thing viz. Birth Rate. Now I am telling you what the danger of contraception only, viz. contraception in our mind and minds of all of us is still a subject of shyness. We are reticent about it. We think it is a person to person matter. I can ask you one question. In this group here, is there one person who has the courage to go and buy a NIRODH from a shop without hesitation? If he will put up his hand, I will promptly tell he is a liar because I do not have the courage, nor do you to go and buy NIRODH from the shops, directly from a shop. We think, and then when shopkeeper is alone we quickly whisper whether latest gadget is available and run away before anybody notices, because he does not want anybody to think he is going to a prostitute or something like that. The trouble is, we have a programme which is considered intimate, very very personal, which we do not like to talk about, I suppose; and to measure the success of how much this has been done, forgetting that all these things, could have been useful, could not have been useful. The program of I.U.D again is still difficult. Sterilisation nobody will like others to know, nobody will like to get up and say, I have been sterilised. Again there is a problem of religious minorities. There is a good sister. Waiting whether I am going to recommend contraception or not. The problem is each religion has its view about contraception. The program of Family Planning, as originated by the founding fathers 40 years ago, was intended to plan the family, to decide what a family wants to do with itself; how many children you want to have; when do you want them, what do you want to do about it, and then it has intended that they be advised about it. But instead of doing that, the program became one of measuring how many inputs have been supplied and you think with that the program has succeeded. It is like to have a Malaria control program in which



you measure success by the amount of chloroquine spent. My almirah full of chloroquine is empty. Therefore Malaria is solved! No! Chloroquine may have been thrown into sea. We have a state like Punjab where couple protection rate (C.P.R.) is 73 and B.R. of 28, Harayana with a C.P.R. of 57 and a B.R. something like 33; and in the other extreme we have state like Kerala with a C.P.R. of 54 and B.R. of 18 and falling. Tamil Nadu is an example not known to many people. Tamil Nadu has reached less than NRR-1 net replacement rate of less than one, and it is the only other state other than Kerala to have achieved this level. Tamil Nadu's CPR is only 56.

Contraception applied in the right time, in the right manner for the right people is certainly very very effective tool to control fertility. But there are other Socio Economic factors such as the age of marriage, literacy, IMR, Spacing. The Birth weight of a child, deciding not to have too many, too fast. All these things induce a person to decide "I will control my Family Size" and that can be a result of many things. Shall we say it is a matter of observing old customs, or observing new customs, it is matter of knowledge. As my good friend Mr Kirubhakaran mentioned in Kerala the Birth Rate has fallen fast or rather gradually over the past 20 years, to some extent, thanks to the fact that the Maharajas of Kerala invested a good portion of their treasury on Education, also due to in a large way to the missionaries who invested largely in literacy. If you understand the word "PALLIKUDAM" what is Palli. In the old days it is church. Kudam is place where people gather. Perhaps also because the Maharajas were interested in Education, rather than other luxuries for themselves, We have Maharajas' colleges, Maharaja's schools, over hundred years old. Key to Family Planning Programme, programme to reduce fertility, may lie in literacy, in reduction of IMR.

Luckily for us, Tamil Nadu Government has understood this. Our people who are part of the Government, part of the staff, part of voluntary organisations have pointed many things. Net result is Birth Rate has come down, continues to slide down, may come down to 15 by 2000 AD. But the path to that is a long one. We have to look at Maternal Health, Child Health. We have to provide facilities, we have to educate, teach people. Now the teaching process seem to be so difficult. That is why Doctors like you who are experts on the subject can contribute much more than civil servants or ex-civil servants like me. Simple things are to be taught not very complicated.



The other day I was in a Health camp in Dharmapuri. There among the things they were giving Iron and Folic acid. Quiet few ladies did not pick up the packet of 100 tablets of iron-folic acid. I asked them why? They said, sir, if we eat these, may be our stool will be black, may be my child may be black and so I will not eat it. I thought that this is a strange belief. That evening when I had dinner with the Collector, the District Medical Officer's wife was sitting with me and when I mentioned this to her, do you know what she told me? She said "Sir, I did not eat these tablets either". I am not joking about this. So many disbeliefs are there not only among the people in the slums, but also at every level. Concepts like consuming colostrum; why has nature provided colostrum? Child which is coming to an absolutely different environment from its well protected environment inside its mother to a totally hostile environment; to provide for that nature has provided a very very simple technique of immunisation. But in Tamil Nadu to some extent, and in many states of India, the belief is one shall not consume colostrum. Only after 4 or 5 days, mother's milk is given to child and during this 4 days, the child is given from time to time water and honey, or honey etc. and the child dies of diarrhoea.

We have an extremely good fruit, rich in vitamins, especially VIt. A called Papaya. This Papaya is a fruit which grows within one year and fruits plentifully and containing several enough dose of Vitamin A that a child can be saved from Blindness and what do we know about Papaya. All we know about Papaya in villages is that it is HOT (USHNAM) and it should not be taken because it causes abortion and so on, and so many things are attributed to papaya, and an average Tamil, in the village will not eat papaya. I sometime wish that it causes all the abortion it is supposed to cause; but it does not; because as you know, in Kerala the Papaya is a green fruit which is consumed quite abundantly and Keralites in olden days never had any shortage of children. Cannot we knock out this belief and I think it can be done. So also about the Drumstick tree. We are talking of midday meal program. Why not we have drumstick, and green leaf of that tree, which is good source of vitamins. It can easily go in to our Midday Meal program but we think of all these as a sort of undignified remedies. It is like the Chief Secretary going on an cycle.

I still remember about 30 years ago, I was collector of Madura. I was camping in Kodaikanal where the inspection bungalow was very peculiarly constructed. It has a fire place which penetrated from the ground floor through higher floor to topmost tier. I was occupying the



floor above the ground floor and was sitting on that day by the side of the Hearth alongwith my wife. On the ground floor were the rest of the staff like Block Development Officer thashildar etc. all discussing among themselves, among other things the whims of the Collector, because I could hear it very clearly through the furnace path. The Block Development Officer was telling "What to do, sir, This Collector instead of coming and inaugrating roads, and the buildings and so on, he asks to grow drumstick trees and papayas. A useless thing for a collector to ask; Does not he know I can not produce these things suddenly, and what is the point of a Papaya tree. Much more dignified for collector to construct buildings than to put up papaya trees." The trouble is over image, the trouble is the image which we have of X-rays, magneto machines and scans, intensive care centres, jeep, cars, vans and eating with a knife and fork and not washing your teeth, and all that. We think What is, imbibed from the west is good, forgetting that in the west they use certain practices for their own reasons which are not current or valid here. Here they may behave differently. This we forget and try to incorporate in our ways of living to our damage. Let us introspect on some of these things.

Lastly, I must mention about the 15 point programme which the Chief Minister has inaugurated just a month ago. I mention this particularly not because the Government has been kind enough to appoint me as Coordinator, Honorary, but because no programme whether it is Health, PWD, Social Welfare, Electricity can be successful unless it is through efforts of several people. Now normally you may think of a Health program as curing disease, or doing that or this. Here is a problem which begins with Child care, Immunisation etc and it goes on to Nutrition, Weighing the child when born and later and to ensuring that the mother is not having too many children, i.e. to say Family Planning, also hospitals becoming baby friendly, talks about gap between any two births, and above all it talks about universalisation of education and ensuring that every child almost compulsorily shall go to school, atleast for 5 years; preventing female infanticide; preventing disability. It is a combination of things. Many departments will have to participate to ensure the success of this program but luckily lot of effort and work have already gone into it and lot of organisations are available, lot of centres are available where all these can take place. I am hoping that something like 29000 child welfare centres will become a health center cum creche cum teaching center; will become a play center, will ultimately become a literacy center also. Even this morning



in some village nearby, I was watching the children play; boy children were playing; hardly did I see any girl child playing. In one small corner, 3 boys were playing with a ring which obviously the girls have brought. 4 girls who were standing had probably brought the ring; they did not have the courage to snatch the ring from the boys. So boys were restlessly playing till the ring fell off accidentally when a girl picked it up and these 4 girls started playing among themselves. I do not say boys should not play. But let us have a place where the other half, the girls, women, adolescent girls, all have a place to gather to talk, to play, have some tamasha, and discuss many things. Let us have competitive sports like ring tennis for them.

I asked in one village a year and half ago why do you want learning? One respondent said we also want to read newspaper and I asked them what do you want to read in the newspaper. One of them said we want to read about Rajiv Gandhi, and another was a little more honest and she said I want to read about Rajnikanth you know he is a popular Tamil Film Super Star.

All these wanting to read, wanting to know, wanting to do things has to be created and imbibed into a good 50% of our population, namely among women. Then only there can be real development. All these are incorporated in Dr. Jayalalitha 15 point programme for women and child welfare. I am hoping to have the cooperation meaning, I have retired, I have no further government service, therefore I am proposing to work for this particular program to ensure that all these things are put together for the welfare of our people.

By 2000 AD, the child of Tamil Nadu will be fairly different creature. Number of children born will be much less; those children will be looked after, those children will have food; those children will have a place to play, will be able to go to school; they will not be sucked into labour; they will be able to read, develop and possibly lift Tamil Nadu from the slums. At that stage we will also have slum clearances in the real sense. This is the ultimate objective of the 15 point programme.

Thank You all.

Dr. Sumathy S. Rao, Secretary, TAMSEARB, IUHPE, proposed a vote of thanks to all dignitaries, and participants. The function concluded with the singing of the National Anthem by all participants and invitees.



# THE DELHI DECLARATION (1993)

1. WE, the leaders of nine high population developing nations of the world, hereby reaffirm our commitment to pursue with utmost zeal and determination the goals set in 1990 by the World Conference on Education for All and the World Summit on Children, to meet the basic learning needs of all our people by making primary education universal and expanding learning opportunities for children, youth and adults. We do so in full awareness that our countries contain more than half of the world's people and that the success of our efforts is crucial to the achievement of the global goal of education for all.
2. WE recognize that:
  - 2.1 The aspirations and development goals of our countries can be fulfilled only by assuring education of all our people, a right promised both in Universal Declaration of Human Rights and in the constitutions and law of each of our countries;
  - 2.2 Education is the pre-eminent means for promoting universal human values, the quality of human resources, and respect for cultural diversity;
  - 2.3 The education systems in our countries have made great strides in offering education to substantial numbers, and yet have not fully succeeded in providing quality education to all of our people, indicating the need for developing creative approaches, both within and outside the formal systems;
  - 2.4 The content and methods of education must be developed to serve the basic learning needs of individuals and societies, to empower them to address their most pressing problems - combating poverty raising productivity, improving living conditions, and protecting the environment - and to enable them to play their rightful role in building democratic societies and enriching cultural heritage;
  - 2.5 Successful education programmes require complementary and convergent actions on adequate nutrition, effective health care and appropriate care and development of the young child, in the context of the role of the family and the community;



- 2.6 The education and empowerment of girls and women are important goals in themselves and are key factors in contributing to social development, well being and education of present and future generations, and the expansion of the choices available to women for the development of their full potential;
- 2.7 The pressure of population growth has seriously strained the capacity of education systems and impeded needed reforms and improvements, moreover, given the age structure of the population in our countries, it will continue to do so throughout the coming decade;
- 2.8. Education is, and must be, a societal responsibility, encompassing governments, families, communities and non-governmental organisations alike; it requires the commitment and participation of all, in a grand alliance that transcends diverse opinions and political positions.
3. CONSCIOUS of the vital role that education must play in the development of our societies, we hereby pledge that by the year 2000 or at the earliest possible moment:
- 3.1 We will ensure a place for every child in a school or appropriate education programme according to his or her capabilities. in order that no child be deprived of education for lack of a teacher, learning material, or adequate space; we pledge this in fulfillment of our commitment under the Convention of the Rights of the Child, which we have ratified.
- 3.2 We will consolidate efforts towards the basic education of youth and adults from public and private sources, improving and expanding our literacy and adult education programmes within the context of an integrated strategy of basic education for all our people:
- 3.3 We will eliminate disparities of access to basic education arising from gender, age, income, family, cultural, ethnic and linguistic differences, and geographic remoteness;
- 3.4 We will improve the quality and relevance of basic education programmes by intensifying efforts to improve the status, training and conditions of teachers, to improve learning contents and material and to carry out other necessary reforms of our education systems;



- 3.5 We will, in all our actions, accord to human development the highest priority at national and other levels, ensuring that a growing share of national and community resources is dedicated to basic education and improving the management of existing resources for education;
- 3.6 We will rally all sectors of our society towards education for all, as we hereby endorse the framework of Action accompanying this Declaration and undertake to review our progress at the national level and to share our experiences among ourselves and with the global community;
4. WE therefore call upon:
- 4.1 International collaborators to raise substantially their support for our efforts to expand our national capacities for expanding and improving basic education services;
- 4.2 International financial institutions, in the context of structural adjustments, to recognize education as a critical investment without imposing pre determined ceilings on such investments, and to promote an international environment to enable countries to sustain their socio-economic development;
- 4.3 The community of nations to join with us in reaffirming the commitment to the goal of education for all and in intensifying their efforts to achieve it by the year 2000 or at the earliest possible moment.

IN ACCORD with the approval by acclamation at New Delhi on the 16th of December 1993, and in witness of our pledge and commitment, we have individually affixed our signatures to this Declaration.

(Indonesia)

(China)

(Bangladesh)

(Brazil)

(Egypt)

(Mexico)

(Nigeria)

(Pakistan)

(India)



# **List of Participants**

---







# LIST OF PARTICIPANTS

## TAMIL NADU

1. Dr. Abraham Balachandran R.  
Health Officer,  
Corporation of Madurai,  
Madurai, TamilNadu.
2. Dr. Alphonse Selvaraj S.  
Filaria - Officer  
41, III Street, Bashyam Nagar  
Chrompet, Madras - 44
3. Dr. (Mrs) Amudha Mozhi  
Ravinathan  
Medical Officer, DFWB,  
7, Vimalapuram, Manali  
Madras - 68
4. Dr. Appavoo, N.C.  
Addl. Director of Public Health  
& Preventive Medicine  
23, Middle Street, Balaji Nagar  
Chrompet, Madras - 44
5. Mrs. Aruna Seralathan M.  
Asst. Professor of Food  
Service and Nutrition,  
Tamil Nadu Agri. University  
Coimbatore -641 003
6. Dr. Arul Pitchai Narayanan M.  
Chairman,  
Arma Medical Foundation  
34, First Main Road,  
Gandhi Nagar, Adayar  
Madras - 20
7. Mr. Arputha Raj A.  
Lecturer, State Inst. of Rural  
Development  
Maraimalai Nagar,  
Chengai MGR Dist.
8. Dr. Athimoolam R.  
Medical Officer  
87, East Garden Street,  
Farelands, Salem - 16
9. Dr. Balachandran T.J.  
DDHS  
4.B. Inoothu Pillaiyar Koil St.  
Thiruvarur - 610 001
10. Dr. (Mrs.) Beulah Rabindradas  
Technical Officer, SHEB,  
Directorate of PH & PM  
171, 2nd North Main Road,  
Kaballeeswarar Nagar  
Neelangarai, Madras
11. Dr. Buvaneswari P.V.  
Medical Officer,  
UHP, MDU-CORPN  
Plot No. 12. J.N. Nagar,  
III Street, P&T Nagar Raod  
Madurai -14
12. Dr. Chandra P.  
Chairman (Prowal) SORNAM  
221, 4th Avenue, Indira Nagar  
Madras - 20

---

### Note :

DDHS : Deputy Director of Health Services



13. Dr. Chandrasekaran A.R.  
DDHS,  
Palani @ Dindigul  
Collectorate Complex,  
II Floor,  
Dindigul - 624 305
14. Dr.Chidambaram  
Hemachandrika  
Asst. Surgeon HQ. Hospital,  
Kanchipuram  
Chengai MGR Dist.
15. Dr. Chockalingam A.  
DDHS  
Beach Road Cuddalore,  
Vallalar Dist. - 607 001
16. Damodaran Shenthamil Selvi  
Asst. Surgeon  
12, Nehruji Road  
Villupuram - 605 602  
SSRP Dist.
17. Dr. Desikachari B.R.  
Danida Advisory unit  
150, Luz Church Road  
Mylapore, Madras - 4
18. Dr. Duraisamy Sabitha.  
Medical Officer  
V th Block, 37/1, 11th Street  
Anna Nagar, Madras - 40
19. Dr. Elango R.  
DDHS  
3.III rd Street Natarajapuram  
North Colony,  
Medical College Rd.  
Thanjavur.
20. Fr. Emmanuel M.  
Vice President, TAMSEARB  
Executive Committee Member,  
SEARB  
12, Murrays Gate Road,  
Madras - 18
21. Mrs. Emmanuel Leelagiri.  
Public Health Nurse  
HFWTC- Pantheon Road  
Egmore, Madras - 8
22. Dr. Eric De Winter  
Danida Advisor  
DANIDA Health Care Project,  
150, Luz Church Road,  
Madras - 4
23. Geetha.R.B  
CDO.CEDMA  
6. Vasantha Garden ,  
I Lane, Ayanavaram,  
Madras - 23
24. Dr. George Sulatha  
Asst. Surgeon,  
Corporation of Madras.  
32, Binny Colony,  
Madras - 51
25. Dr. Ganaselvam J.  
Medical Officer, SOC-SEAD  
Old Goods Shed Road  
Tirucirapalli - 620 001
26. Dr.Gopal S.  
Addl.prof. pediatrics (MMC)  
2A, Athreyapuram Main Road  
Madras - 94
27. Dr. Gopalakrishnan M.  
DDHS  
East IVth Street, Pudukottai.
28. Mr.Gopalakrishnan T.D  
Asst. prof. (Rtd) of Health Ed.  
VII/42, Geethaiyam  
Venus Corner,  
Tellicherry - 670 101
29. Mrs.Grace Kripanithy  
Public Health Nurse  
Nehru Nagar Health Centre  
Korukkupet,  
Madras.



30. Dr. Gurusamy. D  
Dy. Project Director,  
DANIDA Health Care Project  
150, Luz Chuch Road  
Mylapore, Madras-4
31. Mr. Ignacy Robert  
Lecturer  
GIRH and FWT, Gandhigram  
Ambathurai RS.  
Dindigul Anna Dt.
32. Dr. Iqbal Sultan S.  
DDHS  
Kovil Patty @ Tuticorin
33. Dr. Jagannathan Sathya  
Medical Officer  
Primary Health Centre  
Thevur, Nagai Q.M Dist.
34. Dr. D. Jegadeesh Ramasamy  
Principal HFWTC  
Egmore, Madras - 8
35. Dr. V. Jeyasundari  
Instructress in Home Science  
Rural Extn Training Centre  
T. Kallupatti Madurai Dt.
36. Dr. Jeyakumar T.  
Filaria Officer  
Tamil Nadu.
37. Mrs. Jothimani P.  
Training Organisor, Traniners  
Training Centre,  
Avinashilingam Institute for  
Home Science &  
Higher Education For Women  
Coimbatore - 641 043
38. Dr. Kamalakannan B.  
Asst - Surgeon,  
Govt HQ. Hospital  
Cuddalore - 607 001
39. Dr. Kapali V.  
Executive Comittee  
Member - TAMSEARB &  
SEARB  
36, Aspiran Garden  
Madras - 10
40. Dr. R. Krirubakaran  
DDHS  
Collector Complex  
Sivaganga.
41. Dr. Krishnan Murali. K  
Medical Officer, PHC, Padalam  
3, Devarajan Street,  
Vedachalam Nagar,  
Chingleput - 603 001
42. Dr. Kuganantham P.  
Director, C.D. Hospital  
187 T.H. Road,  
Tondiarpet,  
Madras - 81
43. Lobo Ida Maria  
Registered Medical Practitioner  
Avanthi, 169, Greames Lane  
Madras - 6
44. Mrs. Loganayaki E.  
Sector Health Nurse  
Melamathur, PHC  
Thiruchirapalli.
45. Mrs. Malathi Ravindran D.  
Asst. prof of Food Service and  
Nutrition  
T.N. Agri University  
Coimbatore - 641 003
46. Mr. Marcelin M.  
Research Aide. (Retd)  
35, Singara Mudali Street,  
DRR Nagar, Poonamallee  
Madras - 56



47. Mr. Marudhamuthu S.  
Health Education Officer  
CHAD Hospital  
Bagayam, Vellore - 2
48. Mrs. Meenakshi Sundaram  
Raja Meenakshi,  
Medical Officer, IPP - V,  
39, 3/15 - South Boag Road  
T.Nagar, Madras - 17
49. Dr. Meenal R.  
Civil Asst. Surgeon  
18 A, Katpadi Road,  
Gudiyatham,  
North Arcot.
50. Dr. Mohamed Esoof KME.  
DDHS  
Race Course Road,  
Coimbatore - 641 018
51. Dr. Munawar Khan A.  
Joint Director Of Public Health  
& Preventive Medicine,  
259 Annasalai, Madras - 6
52. Dr. Murugesan N.  
Health Education Advisor  
Danida / Danlep  
T. Maria Soosai Nagar,  
Cuddalore - 607 001
53. Dr. Muthalagan Jayaraj  
Medical Officer  
7, Vivekananda Road,  
Chetpet, Madras - 31
54. Dr. Natarajan V.  
Social Psychologist,  
Directorate of Public Health  
118, AI Block III Street,  
Annanagar, Madras - 31
55. Mr. Nelson M.  
Secretary (CEDMA)  
22. Santhome High Road  
Madras - 4
56. Dr. Padmanaba P.  
DDHS  
33, Jones Road,  
Madras - 15
57. Dr. Parthasarthy A.  
Paediatrician,  
E.S.I. Hospital  
Coimbatore.
58. Dr. Paul Kandasamy  
Joint Director of Public Health  
and Preventive Medicine  
259, Annasalai  
Madras - 6
59. Dr. Palani G.  
DDHS  
Collectorate Master Complex  
Sathuvachari  
Vellore, North Arcot Dt.
60. Dr. Parasuram Rajaram  
DDHS  
Collectorate Complex  
Rameswaram Road,  
Ramnad. - 623 501
61. Dr. K.A. Pisharoti  
Executive Member,  
TAMSEARB, SEARB  
F-140, Anna Nagar  
Madras - 600 102
62. Dr. V. Piruthivi  
Joint Director of Public Health  
4. Housing Society Colony  
Viswalingapuram,  
Virugambakkam, Madras - 92



63. Dr. Ponnusamy Paramasivam  
DDHS, Dharapuram  
G.H. Compound, @ Erode  
Periyar Dt.
64. Dr. Prabhu K.P.M.  
Asst. Commissioner (Retd)  
Ministry of Family Planning, GOI  
92-D, P.T. Rajan Salai  
K.K. Nagar, Madras.
65. Dr. H. Pramila  
Addl. Prof. of Child Health  
Parent Craft Centre  
Institute of Child Health  
Egmore, Madras - 8.
66. Dr. Prabhu Clement Devadass  
DDHS  
6. Ramamoorthy Road,  
Chinna Chokikulam  
Madurai - 625 002
67. Mr. Rajasekara Pandey R.  
Development Officer (JAC)  
12, Rosary Church Road,  
Mylapore, Madras - 4
68. Dr. Rajasekara Pandian P.  
DDHS  
Collectorate Complex  
Dindigul,  
Dindigul Anna Dt.
69. Dr. Rajendran K.  
Director,  
Institute of Public Health  
Poonamallee, Madras - 56
70. Dr. Ramalingam R.  
DDHS  
Near Krishnan Koil  
Nagercoil  
Kanniyakumari Dt.
71. Dr. Ramamoorthy N.  
DDHS  
20, Subramania Nagar, III Street  
Trichy - 21
72. Mr. Ramanathan E.  
Lecturer in Health Education  
AP 1700, Street No 103  
Sector No 14  
K.K. Nagar, Madras - 78
73. Dr. Ramalingeswara Rao A.  
Director of PH&PM,  
President, TAMSEARB  
9. Amruthamma Colony,  
SRP. Koil St,  
Jawahar Nagar, Madras - 6
74. Mrs. Ranganathan Rupa  
G.M. (Marketing)  
Apollo Hospitals  
22. Greams Lane  
Madras - 6
75. Mrs. Roselet Joy C.  
Community Health Nurse  
Govt. PHC, Karai,  
Trichy Dt.
76. Dr. Richard J.  
Professor, Dept of BioStatistics  
Christian Medical College,  
Vellore - 632 002
77. Sr. Rita Thyveetil  
Co-Ordinator SOC-SEAD  
Old Goods Shed Road,  
Tiruchirappalli - 620 001
78. Mrs. Samuel Miriam  
Lecturer  
Madras Christian College  
Tambaram  
Madras - 59



79. Dr. Sargunam G.  
Asst. Prof., S.P.M.  
3/3000, Vennatrangarai  
Thanjavur - 3
80. Mrs. Sarojini S.  
Health Education Instructor  
72. Thiruvalluvar Nagar,  
Alandur, Madras - 16
81. Dr. Sasikala M.S.  
Medical Officer, PHC,  
18 Parathasarthy Nagar  
Madurai - 14
82. Dr. Sathiamoorthy Vijayanagam  
Asst. Surgeon  
57. Barathidasan St  
Mamallan Nagar, Kanchipuram.
83. Dr. Shahjahan M.  
Asst. Surgeon  
23. 5th Main Road  
Jawahar Nagar, Madras - 82
84. Dr. Sheelakumari M.  
Medical Officer  
20. IInd Cross St  
Indira Nagar, Madras - 20
85. Dr. Sivagami Sundari C.  
Medical Officer,  
Corpn. of Madurai  
5 New HIG Flat  
Annanagar, Madurai - 20
86. Dr. Sivarama Moorthy V.  
DDHS  
5th Floor - B Block,  
Collectorate, Vellore.
87. Dr. Somasekar R.  
Asst. Surgeon  
Plot No. 160 Ist St  
Venkateswara Nagar  
Polichalur, Madras - 74
88. Mrs. Sulochana N.  
Health Educator  
Kasthuriba Hospital  
Gandhigram  
Ambathurai R.S, Dindigul Dt.
89. Dr. Subramani K.  
DDHS  
Jail Hill Road  
Ooty - The Nilgris.
90. Dr. Sumathy Rao  
Secretary, TAMSEARB  
Y - 137 Anna Nagar  
Madras - 40
91. Dr. Sundar Rao P.S.S.  
Professor & H.O.D. of  
Biostatistics  
Christian Medical College  
Vellore - 632 002
92. Dr. Surender Manjula  
Civil Surgeon  
4. Gajapathy Road  
Kilpauk,  
Madras - 10
93. Mrs. Susan Mathew  
Programme Officer  
'Asha Nivas'  
9 Rutland Gate Vth St  
Madras - 6
94. Mrs. Swaminathan Mina  
Director, Project - Access  
M.S. Swaminathan Research  
Foundation,  
3rd Cross St,  
Taramani, Madras - 113
95. Dr. Syed Fiaz Peeran  
Joint Director of Public Health  
18, Jhani Jhani Khan Rd  
Madras - 14



- |  |   |
|--|---|
| <p>96. Dr. Thangavelu Chandra Mohan<br/>Medical Officer<br/>Community Health Centre<br/>Ammapet, Thanjavur 614 401</p> <p>97. Dr. Thirugnana Sambandam<br/>Retd. Director, ICH, Ms - 18<br/>8, 1st Block, II Main Road,<br/>Anna Nagar East<br/>Madras - 600 102</p> <p>98. Dr. Umapathy M.<br/>Medical Officer<br/>Manamelkudi Post<br/>Pudukkottai Dt.</p> <p>99. Dr. Vadivelu Poorvadevi<br/>Asst. Surgeon<br/>5A, Bharathythasan St<br/>Manjakuppam<br/>Cuddalore, Vallalar Dt.</p> <p>100. Mr. Varadharajulu Mohanraj<br/>Asst. Project Officer (W.D)<br/>Dist. Rural Dev. Agency<br/>Collectorate, Periyar Dt.</p> <p>101. Dr. Varadappan Baskaran<br/>Asst. Surgeon<br/>Govt. Hospital<br/>Tirukoilur<br/>Villupuram Ramasamy<br/>Padayachiar Dt.</p> <p>102. Mrs. Vasantha K.<br/>Training Associate<br/>Trainers Training Centre<br/>Avinashilingam Deemed<br/>University, Coimbatore - 43</p> <p>103. Dr. Venkateswara Rao K.<br/>Director<br/>Voluntary Health Service<br/>Adayar, Madras - 113</p> | <p>104. Dr. Viswanathan K.C.<br/>Deputy Director<br/>Directorate of Medical and<br/>Rural Health Services<br/>(PHC Wing), Madras - 6</p> <p>105. Dr. (Mrs.) Yasodha<br/>Shanmugasundram<br/>Principal, Ethiraj College<br/>Madras - 600 105</p> <p>106. Dr. G. Vittal Raj<br/>Principal, HFWTC,<br/>Salem</p> <p><b>PARTICIPANTS FROM TINP</b></p> <p>107. Miss. Ambika V.M.<br/>Dist. Project Nutrition Officer<br/>49, Big Street,<br/>Thiruvannamalai,<br/>T.Sambuvarayar Dist.</p> <p>108. Mr. Anbalagan K.<br/>Dist. Communication Officer<br/>1, Convent Street,<br/>Pudupalayam,<br/>Cuddalore, Vallalar Dist.</p> <p>109. Mr. Bakkiyarajan S.<br/>Dist. Communication Officer<br/>110. Balaji Road<br/>Krishna Nagar,<br/>Vellore - 1, N.A.A. Dt..</p> <p>110. Tmt. Boomadevi T.<br/>Dist. Project Nutrition Officer<br/>10, Rajaji Street,<br/>College Road, Virudunagar</p> <p>111. Mr. Gnanasekaran G.<br/>Dist. Communication Officer<br/>99, Spencers Compound,<br/>Dindugul</p> |
|--|---|
- 

**TINP** : *Tamil Nadu Integrated Nutrition Project*



112. Mr. Gnanavelu A.  
Editor  
Communications &  
Training Centre,  
Taramani, Madras - 113
113. Mrs. Janaki Bai P.  
Dist. Project Nutrition Officer  
154, Weekly Market Road,  
Sivagangai, P.M.T. Dist.
114. Mrs. Jayalakshmi G.  
Dist. Project Nutrition Officer  
1, Convent Street,  
Pudupalayam,  
Cuddalore - 602 001
115. Mrs. Jeyarani P.  
Production Asst.  
Communication & Training  
Centre  
Taramani, Madras -113
116. Mrs. Kannammal R.  
Dist. Project Nutrition Officer  
128, Sankar Nagar  
Hasthampatty Post.  
Salem - 636 007
117. Mr. Loganathan J.  
Audio Visual Operator  
Communication Training  
Centre.  
Taramani, Madras -113
118. Mrs. Mangaiyarkkarasi D.  
Dist. Communication Officer  
1/143 Melamadai,  
East Street, Madurai - 20
119. Mrs. Maria Rosaline Daniel  
Dist. Communication Officer  
10 A. College Road  
Virudhu Nagar.
120. Mr. Marimuthu N.  
Dist. Communication Officer  
14, Gowri Villas Palace,  
Ramanathapuram - 1
121. Mr. Murugesan J.  
Asst. Director  
Communication Training  
Centre,  
Taramani, Madras - 113
122. Mr. Muthuvarisai Ahmed  
D.C.O.  
Varasanthai Road,  
Sivagangai, P.M.T. Dist
123. Mrs. Nandhini Rajendran  
Chair Person  
Social Welfare Board  
Tamil Nadu
124. Mrs. Navamani  
Dist. Project Nutrition Officer  
1/143 Melamadai East Street,  
Madurai - 20
125. Mrs. Packiam R.  
D.C.O.  
128, Sankar Nagar, Salem
126. Mr. Panneer Velu C.  
D.C.O  
Dist. Project Nutrition Officer  
Tiruchi
127. Mr. Paramasivam P.  
D.C.O.  
Dist. Communication Officer  
(TINP), Erode
128. Mr. Ponmony S.  
Dist. Project Nutrition Officer  
4/49 C.G.E. Colony  
Tuticorin, V.O.C.Dist



129. Mrs. Poongothai M.  
D.C.O.  
49. Big Street,  
Thiruvannamalai.
130. Mrs. Pooval G.  
Dist. Project Nutrition Officer  
314, Nethaji Road, Erode - 1
131. Mr. Poyaamozhi G.  
Librarian,  
Communication Training  
Centre  
Taramani, Madras - 113
132. Mrs. Radha Bai T.  
Dist. Project Nutrition Officer  
14 Gowri Vilas Palace,  
Aranmanai, Ramnad
133. Mr. Ramar S.  
D.C.O.  
5. Kumarasamy Nagar  
Aerodrome Po  
Coimbatore - 641 014
134. Mr. Ravendran N.  
D.C.O  
2F. 9th Street,  
Appavoo Nagar, Dharmapuri
135. Mr. Sarabu A.  
Senior Instructress (Health)  
Communication Training  
Centre  
Taramani, Madras - 113
136. Mr. Selvaraj R.  
D.C.O.  
13, Samad School Street,  
Khaja Nagar, Trichy - 20
137. Mrs. Senthamarai R.R.  
D.P.N.O  
98-99 Spencer Compound  
Dindigul - 624 003
138. Mrs. Shantha E.V  
Joint Co-ordinator (Nutrition)  
48 L.B. Road  
Adayar, Madras - 20
139. Mrs. Shanmuga Vadivoo P.  
D.P.N.O  
2, Rhanivs Street,  
Palayamkottai  
Tirunelveli - 2
140. Mr. Sivakari Muthu M.  
Artist Cum Designer  
CTC - Taramani,  
Madras - 113
141. Mr. Sundara Das  
D.P.N.O.  
110, Balaji Street  
Krishna Nagar,  
Vellore, N.A.A. DT.
142. Mrs. Valsarajan Annie  
Deputy Director  
(Communications)  
C.T.C. Taramani,  
Madras - 113
143. Mrs. Vimala S.  
D.P.N.O  
9. Appavoo Nagar Vth Street,  
Dharmapuri.
144. Mr. Thewdar Rajesekar K.  
D.C.O.  
4/49 C.G.E. Colony  
Tuticorin,  
V.O.C. Dist.
145. Mrs. Yamuna Rani  
D.P.N.O  
5, Kumarasamy Nagar,  
Aerodrome Po.  
Coimbatore - 641 014



## PARTICIPANTS FROM ICDS

146. Mrs. Kamala K.  
Deputy Director (ICDS)  
Directorate of Social Welfare.  
Chepauk, Madras -5
147. Mr. Kumaravel G.  
Communication Officer (ICDS)  
772, T.H.Road, Thiruvottiyur,  
Madras - 600 019
148. Mrs. Lalitha Gopalakrishnan  
Programme Officer (ICDS)  
27, Venketeswara Chawdry  
Street,  
Tambaram West, Madras - 45
149. Mrs. Malathy C.  
Programme Officer (ICDS)  
I.C.D.S. Cell, Ooty, The Nilgris
150. Miss. Meenakshi V.  
Programme Officer (ICDS)  
State Cell, ICDS,  
Director of S.W.  
Chepauk, Madras -5
151. Dr. Murugan S.  
DDHS  
Directorate of Social Welfare  
Chepauk, Madras - 5
152. Mr. Paramanandan A.  
Asst. Project Officer, Dwera  
Collectorate, Sathavachari,  
Vellore. N.A.A. Dt.
153. Tmt. Radha Srinivasan  
Programme Officer, ICDS  
Lakshmipuram, Pudukottai.
154. Mrs. Sivathanu Amirtha  
Mennumbal  
DD/Women Welfare  
Directorate of Social Welfare,  
Chepauk, Madras - 5

## PARTICIPANTS FROM EDUCATION DEPT.

155. Mr. Arunachalan G.  
School Asst., Govt. High School,  
Pothukovil  
Tirunelveli - 627 435
156. Mr. Baskaran S.  
P.G. Asst.  
Govt Higher Sec. School,  
Natham - Kovil Patty  
Dindigul Anna Dt.
157. Mr. Ganesan N.  
Deputy Inspector of Schools  
The DEO, Thiruppathur  
N.A.A. Dt. - 635 601
158. Mr. Govindarajan S.  
B.T. Asst  
Govt High School  
Mutham Via -Nagore - 611 002
159. Miss. Kalavalli V.M.  
P.G. Asst.  
Govt Higher Sec. School  
Athoor,  
Dindigul Anna Dt. 624 701
160. Mr. Kandaswamy K.P.  
School Asst.  
Govt High School  
Goodanagarm N.A.A.Dt.
161. Mr. Margavelu J.  
B.T. Asst  
Govt Higher Sec. School  
Santhavasal, 606 905  
T. Sambuvarayar Dist.
162. Mr. Mathius Maria Susai  
P.G. Asst.  
Govt Higher Sec. School  
Marthandam,  
Kanniyakumari Dt.



163. Mr. Murugan K.  
School Asst.  
Govt High School, Thiruvathur  
T.Sambuvarayar Dt.
164. Mr. Subbiah Natarajan  
P.G. Asst.  
S.L.B Govt Higher Sec. School  
Nagercoil - 629 001
165. Mr. Ramalingam K.  
School Asst.  
Govt High School  
Jagir Ammapalayam Po,  
Salem Dt. 636 302
166. Mr. Ramanathan M.  
B.T. Asst  
Govt Boy's Higher Sec. School  
Kattumannar Koil,  
S.A. Vallalar Dist.
167. Mr. Rathamani S.  
Physical Director  
Govt Girl's Higher Sec. School  
Perundurai - 638 052
168. Mr. Renganathan M.  
B.T. Asst  
Jawahar Govt High School  
Tirunelveli - 627 006
169. Mr. Sankaran V.  
School Asst.  
Govt High School, Ambal,  
Poonthottam (via) 609 503
170. Mr. Sengodan P.  
Head Master  
Govt High School  
Veerappan Chatram,  
Erode - 638 004
171. Mr. Sharfuddin  
P.G. Asst.  
Islamiah Higher Sec. School  
Melvisharam 632 509  
N.A.A Dt.
172. Sigamani E.  
P.G. Asst.  
Govt Higher Sec. School  
Santhavasal  
T.Sambuvarayar Dist. - 606905
173. Thulasiraman S.  
P.G. Asst.  
Sri Brahadambal Govt Higher  
Sec. School  
Pudukkottai - 622 001
- PARTICIPANTS FROM DHE  
COURSE, GIRH & FWT**
174. Binod Bindu Sharma  
DHE Student  
Midwestern Regional .  
Eye Care Centre,  
Fateh Bal Eye Hospital,  
Nepalgunt, Nepal
175. Dand Pani Satpathy  
DHE Student  
BEE, Jagarnath Prasad PHC,  
Ganajam Dist, Orissa
176. Dass Gunamani Das  
DHE Student  
BEE, Derabis PHC,  
Kendrapara Dist. Orissa
177. Kaliaperumal K.  
Senior Training Officer  
(Communication & Media),  
GIRH&FWT

---

**DHE : Diploma in Health Education**

**GIRH & FWT : Gandhigram Institute of Rural Health & Family Welfare Trust.**  
**P.O. Ambathural R.S. Pin : 624309**



178. Kandasamy V.  
Lecturer In Behavioral Science,  
GIRH&FWT
179. Khaleel Ahamed  
DHE Trainee  
GIRH&FWT
180. Krishna Samy P.  
DHE Trainee  
42, Muthial Reddy Nagar,  
Adambakkam, Madras - 88
181. Leelavathy M.  
DHE Trainee  
3-74, North Street,  
Pasupathy Kovil, Tanjore.
182. Magadum D.S.  
DHE Trainee  
Borgal,  
Hukeri TK,  
Belgaum, Karnataka
183. Mohammed Ishaq M.  
DHE Trainee  
BEE, PHC Paragada  
Karnataka - 561202
184. Moniyappan M.  
DHE Trainee  
GIRH&FWT
185. Padhi Jeebam Chand  
DHE Trainee  
BEE, CHC,  
Borigumma 764056  
Koraput Dist, Orissa
186. Paguthappan Rajeswari  
Professor of Health Education  
GIRH&FWT
187. Parthipan N.  
DHE Trainee  
93. Muthumariamman  
Koil Street,  
Pondicherry - 605 001
188. Pattanaik Naba Kishor  
DHE Trainee  
CHC Agalpur,  
Bolangir Dist, Orissa
189. Shanmugam P.  
Senior Training Officer,  
GIRH&FWT
190. Sivagnanam  
Lecturer, GIRH&FWT
191. Srinivasan A.  
DHE Trainee  
GIRH&FWT
192. Subramaniam K.  
DHE Trainee  
GIRH&FWT
193. Thapp Manju  
DHE Trainee  
Bankelawm,  
W.No. 12, Nepalgumj,  
Nepal
194. Veera Kumar V.  
DHE Trainee  
11 Anna Nagar,  
Shanmuga Puram  
Palni, Dindigul Anna Dt.
195. Venkatesan C.  
Lecturer  
GIRH&FWT, Ambathurai R.S,  
Dindigul Anna Dist, - 624 309



## ANDHRA PRADESH

196. Dr. Hassan S.H.  
Director Regional Training  
Centre (FPAI) 8-2-675/1/A.  
Road - 13.  
Bangaru Hills, Hyderabad - 34
197. Kappala Neelankanta  
Kondala Rao.  
Project Director,  
ODA. Health Project.  
30-15-56. OABA Gardens  
Visakapatanam - 20
198. Prof. Mahadevan K.  
Head & Prof. Dept of  
Population Studies  
S.V. University  
Tirupathi - 517 502
199. Mohmed NivasKhan  
Health Asst.  
41-531-A, Kothapeta.  
Kurnool  
Andhra Pradesh - 518 004
200. Valvekar Hemanth Kumar  
Population Education Officer  
Population Education &  
Information Centre - FPAI.  
3-6-190/A/2  
Himayat Nagar, Hyderabad

## GUJARAT

201. Dr. Capoor Indu  
Director CHETNA  
(Centre for Health  
Education Training and  
Nutrition Awareness)  
Lilavati Lalbai Banglow Civil  
Camp Road,  
Ahmedabad - 380 004  
Gujarat.

202. Jyoti Gade  
Senior Field Officer, 'CHETNA'
203. Kakunja  
Project Resource Person  
CHETNA
204. Khan Andrea  
CHETNA
205. Madsen Lene  
CHETNA
206. Rathod Prasadika  
Project Associate  
CHETNA
207. Shukla Minaxi  
CHETNA
208. Sonal Mehta  
Prog. Resource Person  
CHETNA

## KARNATAKA

209. Dr. Abdul Salam  
Tutor in Statistics  
Dept. of Community Medicine  
Ameen Medical College  
Bijapur - 586 108
210. Dr. C. Achuthan  
Retd. Joint Director of  
Health Services  
"ANDAL KRUPA"  
1730, 17 Cross  
M.C Layout, Vijaya Nagar,  
Bangalore - 560 040
211. Dr. Ashok Sahni  
Prof & Director  
Indian Society of Health  
Administrator  
15/37 Cambridge Road Cross  
Ulsoor, Bangalore - 8



212. Dr. Ganga Mallaiah  
Dy. Director Information  
Directorate of Health and  
F.W. Services  
I - Block II Cross  
B.Nagar, Bangalore - 560 079

213. Phaneendra Rao R.S.  
Prof & Head & Director  
Dept of Community Medicine  
The Kasturba Medical College  
Manipal - 576 119

214. Dr. Ramakrishna V.  
SEARB, Regional Director  
6. V.R. Road  
Madhava Nagar  
Bangalore - 560 001

215. Dr. Rajanna M.S  
Asst. Prof in Community  
Medicine  
398 Saraswathi Nagar  
Babuji Layout, Nagarabhavi Rd,  
Vijayanagara  
Bangalore - 560 040

216. Mr. Settappa  
Administrative Officer SEARB  
147/A 39th Cross, 9th Block,  
Jayanagar, Bangalore

217. Mr. Subbe Gowda H.B.  
Advisor (SEARB)  
188, West of Chord Road  
12th "A" Cross  
Bangalore -560 086

218. Dr. Sudha Xirasagar  
Co-ordinator  
Publication & Research  
Indian Society of Health  
Administrators  
104 (15/37) Cambridge Road  
Cross, Ulsoor,  
Bangalore - 560 008

## KERALA

219. Dr. Babu Mathew  
Professor Regional Cancer  
Centre, "RAINBOW"  
Jainagar, Trivandrum - 11

220. Mr. Kochu Rani Mathew  
Programme Officer  
Kerala Water Authority  
Socio Economic Unit  
Kollam - Kerala

221. Mr. Kurup Balachandra  
Executive Co-Ordinator  
Socio-Economic Unit  
Vellayabalam  
P.O Box 6519  
Trivandrum - 695 033

222. Mrs. Mathew Thresiamma  
Programme Officer  
Socio Economic Unit  
Kerala Water Authority  
Trichur, Kerala

223. Philip Chachy  
Kalachandra House  
Chingavanan  
Kottayam - 686 531

224. Mrs. Remadevi OT.  
Programme Officer  
Socio Economic Unit  
Kerala Water Authority  
Malamparamba  
Calicut - 673 009

225. Mrs. Vijayalakshmi Ammal  
Mass Media Officer  
"INDEEVARAM"  
Opp/Govt.ups. Kumarapuram  
Medical College P.O.  
Trivandrum - 11, Kerala.



## MAHARASHTRA

226. Dr. N.H. Antia N.H  
Director  
Foundation for Research in  
Community Health,  
84 A R.G Thadani Marg  
Bombay - 400 018
227. Dr. (Mrs) Gadkari Anuradha S.  
Asst. Director, (Scientist)  
E.I.R.A Division  
Neeri  
Nagpur - 400 020
228. Dr. P.B. Pillai  
Reader  
Dept. of P.S.M  
A.F.M.C Pune
229. Wing Commander  
T.S. Raguraman  
Reader,  
Dept of Pediatrics  
Armed Forces Medical College  
Pune - 411 040

## NEW DELHI

230. Dr. Saroj S. Jha  
Regional Advisor  
Health Education  
WHO Regional Office  
South East Asia  
WHO House  
Indraprastha Estate  
New Delhi - 110 002
231. Ved Rajani  
Project Manager  
USAID  
B-28 Institutional Area  
Qutub Hotel Road  
New Delhi - 110 016

## PUNJAB

232. Singh Rajinder  
Dist Health Officer  
Civil Surgeon  
Rup Nagar, Punjab
233. Raajinder Singh  
Dist. F.W. Officer  
Dist F. W. Office  
Po. Gurdaspur. Ps

## BANGLADESH

234. Farque Ahmed  
Programme Officer  
The World Bank  
Resident Mission  
3A Parlibag  
Dhaka - 1000, Bangladesh
235. Shareef Mahboob  
Programme Officer  
UNICEF P.B. No. 58  
Dhanmondi R.A.  
Road No. 44  
Dhaka, Bangladesh
236. Mrs. Zaheda Ahmed  
Consultant  
B-40 Is Pahani  
Century Apartment  
Mogh Bazar  
Dhaka, Bangladesh



## NEPAL

237. Kalavathy Pandey  
Health Training Officer  
Rural Water Supply &  
Sanitation Project  
P.B. No. 12  
Butwal, Nepal
238. Mr. P.P. Shrestha  
President Health Education  
Association of Nepal  
Regional Vice President  
of SEARB  
Chakupet  
PB 5 Lalitha Pur, Nepal
239. Miss. Urmila Shrestha  
Health Training Officer  
Rural Water Supply &  
Sanitation Project  
(FINNIDA)  
Yogikuti PB. 12  
Butwal, Nepal

## INTERNATIONAL

240. Dr. Colin L. Yarham  
Consultant  
Health Education & Promotion  
Australia
241. Hindson Paul  
77. Ormadace Road  
Yeronga Old  
4104,  
Australia
242. Mr. Hangendoorn  
Regional Vice President  
IUHPE - Europe,  
Netherland
243. Dr. Matti Rajala  
President IUHPE  
Paris,  
France



**TAMSEARB**  
**Members of IUHPE**

---



TAMBEARD

Members of IUPPE

---



# TAMSEARB MEMBERS OF IUHPE

- |  |  |
|--|--|
| <p>1. Dr. R. Abraham Balachandran<br/>(SB-TN-41)<br/>Sarah Nursing Home<br/>199, North Car Road<br/>Tuticorin - 628 002, India</p>           | <p>8. Dr. N.C. Appavoo<br/>(SB-TN-8)<br/>25, Middle Street<br/>Balaji Nagar, Chrompet<br/>Madras - 600 044</p>                                     |
| <p>2. Tmt. K.R. Alamelu<br/>Prmy. Health Center<br/>Namagiripet - 637 406<br/>Salem Dist.</p>  | <p>9. Dr. R. Arvindaksha Kumar<br/>(LM-TN-111)<br/>22, College Road<br/>Sekkalai, Karaikudi - 623 002</p>  |
| <p>3. Mr. Alex Eapen<br/>Assistant Research Scientist<br/>Malaria Research Center<br/>1304, Anna Nagar East Extn<br/>Mugappair - 600 050</p> | <p>10. Dr. (Mrs.) T. Aruna (LM)<br/>123, Sanjeevaroyan Koil St<br/>Old Washermanpet<br/>Madras - 600 021</p>                                       |
| <p>4. Smt. A. Alphonsa Mary<br/>(PLM)<br/>Oddapatti,<br/>Dharmapuri - 636 705</p>  | <p>11. Dr. T.V. Asokan<br/>(LM-TN-130)<br/>Institute of Mental Health<br/>Madras - 600 010</p>   |
| <p>5. Dr. S. Amudhavalli<br/>(SB-TN-103)<br/>Medical Officer, P.H.C.<br/>Gajel Naicken Patti<br/>Tirupattur Taluk - 635 901</p>              | <p>12. Dr. D.J. Augustin<br/>(SB-TN-21)<br/>9-1, First Main Road<br/>Gandhi Nagar, Adayar - 20</p>   |
| <p>6. Mrs. Annie Valsarajan<br/>(PLM)<br/>58, Royapettah High Road<br/>Mylapore - 600 004</p>  | <p>13. Dr. R. Ayyathurai<br/>(SB-TN-20)<br/>32, 3rd Street, Tatabad<br/>Coimbatore - 641 012</p>   |
| <p>7. Dr. P.J. Anuradha<br/>(SB-TN-80)<br/>25, 4th Main Road<br/>Gandhi Nagar, Adayar - 20</p>   | <p>14. Dr. T.J. Balachandran<br/>(SB-TN-79)<br/>Dy. Director of Health<br/>Services<br/>B-Block, IInd Floor Collectorate<br/>Vellore - 632 009</p> |

---

## Note :

1. Members as on .....
2. LM : Life Members, PLM : Part-Paid Life Member
3. SB : TN/LM-TN - Life Member thro. Tamil Nadu Chapter (Number following SB-TN (or) LM-TN is the serial number of Life Memberships of SEARB - IUHPE



15. Sri. R. Balasubramani  
Block Health Supervisor  
(Opp. to Fire Station)  
Periyapatti Road  
Sandaipetti Podur  
Nammakal Tk - 637 002
16. Tmt. M. Bama  
W/o T.T. Manoharan  
58C, Paluthus Street  
Tiruchengodu - 637 211
17. Dr. C.M. Banumathy  
23, V.V. Koil St  
R.M.O. Quarters  
C.Choolai, Madras - 600 010
18. Dr. P. Baskaran  
(LM-TN-125)  
Keeramangalam Post  
Pudukkottai Dist. - 614 624
19. Dr. S.N. Baskaran  
(SB-TN-98)  
26, Mangammal St  
Jolarpettai - 635 851
20. Dr. Marvin Manoah Baylis  
(SB-TN-115)  
7/633, Alwar Nagar  
Nagamalai Pudukottai  
Madurai - 625 019
21. Dr. P. Chandra  
(SB-TN-26)  
"SORNAM"  
221, 4a - Avenue  
Indira Nagar, Madras - 20
22. Dr. K. Chandramohan  
(SB-TN-46)  
Assistant Surgeon  
C-65, IV Cross  
Thillai Nagar  
Trichy - 620 018
23. Dr. P. Chellammal  
(LM-TN-139)  
Sri Gokulam Hospital  
3/60, Meyyanur  
Salem - 636 004
24. Mr. C.S. Cherain  
(SB-TN-16)  
Health Education Material  
Officer  
German Leprosy Relief  
Association  
4, Gajapthy Street,  
Shenoy Nagar, Madras - 30
25. Dr. P. Chezhan  
(SB-TN-50)  
Assistant Surgeon  
10/12 Udaiar Street  
Kattur, Trichy - 621 706
26. Mr. S. Chinnu  
Prmy. Health Center  
Pillanur  
Gurusamy Palayam  
Salem Dist. - 637 402
27. Dr. P.S. Chitakala  
(LM)  
17, Pandaram St  
Purasaiwalkam  
Madras - 600 007
28. Dr. Chita Sampath  
(LM-TN-141)  
C.S. Hospital  
Gandhi Road,  
Salem - 636 007
29. Dr. G. Chowdappa  
(SB-TN-17)  
1192, Dr. Natesan Road  
Ashok Nagar  
Madras - 600 086



30. Dr. A. Delvamani  
(SB-TN-43)  
Medical Officer  
PHC Varadarajanpet  
Trichy - 621 805
31. Dr. Derek Lobo  
(SB-TN-27)  
Director  
Referral Hospital and  
Leprosy Center  
5, Gajapathy Street  
P.B : 2535  
Madras - 600 030
32. Mr. P. Devan  
Block Health Supervisor  
Arasanatham  
Salem - 637 020
33. Mr. R. Devarajan  
23, C4, CHB Colony  
Tiruchengodu  
Salem - 637 211
34. Dr. R. Elango  
(SB-TN-78)  
3, 111rd Street  
Natarajapuram North Colony  
Medical College Road  
Tanjavur - 613 004
35. Dr. P. Elangovan  
(SB-TN-47)  
1-A5, Sambasivam Pillai St  
Ariyalur  
Trichy - 621 704
36. Fr. Emmanuel M. Pillai  
(SB-TN-15)  
12, Murray's Gate Road,  
Madras - 600 018
37. Tmt. M. Eswari  
W/o V. Jayagopal  
Alavaipatty  
Salem - 637 505
38. Dr. M. Ezhilarasi  
(SB-TN-53)  
16 A, Main Road  
Thuvarankurchi  
Trichy - 621 306
39. Dr. V. Farook Khan  
(LM-TN-127)  
4/15 North St,  
Kottaipattinam P.O.  
614 619
40. Dr. A. Gajendran  
(SB-TN-101)  
18, Cutchery St,  
Tirupattur  
N.Arcot - 635 601
41. Dr. G. Gandhi  
(LM-TN-112)  
C/o. Dr. K. Raghavan  
1, Shanmugam Pillai St  
Sekkali  
Karaikudi - 623 002
42. The Director  
(SB-TN-23)  
Gandhigram Institute of  
Rural Health and FW Trust  
Ambathurai - 624 309
43. Dr. S. Ganesh Ram  
(LM-TN-136)  
Medical Officer  
P.H.C. Arasanur  
Sivaganga Dist.
44. Dr. M. Gopalakrishnan  
(LM-TN-130)  
Dy. Director of  
Health Services  
Pudukottai - 622 001
45. Dr. N. Gopalakrishnan  
(LM-TN-117)  
Medical Officer  
P.H.C. Mallakottai, PMT. Dist.



46. Dr. R. Gopalakrishnan  
(LM-TN-142)  
Srinivasan Naicken St  
Naickerapatti  
Dindugul Anna Dist. - 624 615
47. Dr. M. Gopalaswamy  
(SB-TN-18)  
7, UVS Iyer Street  
MES Road  
East Tambaram - 600 059
48. Dr. E.V. Gopinathan  
(SB-TN-70)  
Dy. Director of  
Health Services  
Coimbatore - 641 018
49. Dr. S. Gurunathan  
(SB-TN-110)  
50, Balakrishnan Naicken St  
Madras - 600 033
50. Dr. M. Hariharan  
(SB-TN-67)  
45, Adam St  
Madras - 600 004
51. Dr. M. Indrani  
W/o Dr. G. Elangovan  
(SB-TN-76)  
19, Chokkanathan Nagar  
Maduravoyal,  
Madras - 600 102
52. P. Indira Bai  
C.458, 5th Cross Street  
Periyar Nagar  
Madras - 600 082
53. Dr. S. Iqbal Sultan  
(SB-TN-59)  
K.K. Road, Erradi,  
Ramnad Dist. - 623 515
54. Dr. K. Jawahar  
(SB-TN-89)  
Medical Officer  
PHC - Madhanur  
N. Arcot Dist - 635 804
55. Dr. K.R. John  
(SB-TN-12)  
Dept. of Comy. Medicine  
C.M.C. Vellore - 632 002
56. R. Kalaivanan  
(SB-TN-51)  
1, Mariamma Koil Street  
Lalapet,  
Trichy - 639 105
57. Dr. E. Kalivaradhan  
(SB-TN-92)  
Kiliyanur,  
S. Arcot - 604 102
58. Mrs. A. Kamala  
31, High Road,  
Egmore  
Madras - 600 008
59. Sri. V. Kandaswamy  
Health Supervisor  
PHC- Valavanthi Nadu  
Kolli Hills  
Salem - 637 411
60. Dr. V. Kapali  
(SB-TN-1)  
36, Aspiran Gardens  
First Street  
Madras - 600 010
61. Tmt. R. Kasturi  
PHC Mullukuruchi  
Rasipuram,  
Salem - 636 118



62. Medical Superintendent  
Kasturba Hospital  
(LM-TN-121)  
Gandhigram Trust  
Ambathurai  
Dindugul Anna Dist - 624 309
63. Tmt. A. Kavitha Muthusamy  
4/112 G - Anna Nagar  
Reddipatty, Nammakkal  
Salem - 637 002
64. Dr. R. Kirubakaran  
(SB-TN-42)  
Dy. Director of  
Health Services  
Devakottai,  
P.M.T.Dist. - 623 303
65. Mr. G. Kittu Rao  
(SB-TN-11)  
570, Anna Salai  
Madras - 600 018
66. Dr. Kowsalya  
(LM:TN-114)  
Medical Officer  
PHC Puduvoyal - 623 108
67. Mr. A. Krishnan  
4/50 J - Nagarajapuram  
Vasanthapuram, P.O.  
Nammakkal - 637 002
68. Dr. K. Krishnan  
(SB-TN-65)  
3, Bharathi Street  
K.K. Nagar  
Madurai - 625 020
69. Dr. P. Krishnamurthy  
(SB TN-5)  
Plot.No:24 Laxminagar Extn.  
Madras - 600 104
70. Mr. K. Kumaraswamy  
Block Health Supervisor  
PHC - Belukurichy  
Salem - 637 402
71. Mr. G. Kumaravel  
(SB-TN-85)  
772, T.H. Road  
Thiruvottiyur,  
Madras - 600 019
72. Mr. S. Kuppusamy  
Block Health Supervisor  
164, A- Angalaman Koil Street  
Idappadi P.O - Salem
73. Tmt. M. Lakshmi  
(SB-TN-19)  
680, Sathyavani Muthu Street  
K.K. Nagar, Trichy - 620 021
74. Smt. N. Lakshmi Radhakrishnan  
27, IV St, Jeeva Nagar  
New Washermanpet,  
Madras - 600 081
75. Sri. N. Lakshmanan  
Block Health Supervisor  
44 M - East Colony  
B. Konarapalayam - 638 183
76. Mrs. E. Leelagiri  
(SB-TN-58)  
HFW Training Center  
Egmore - 600 008
77. Dr. K. Machavallavan  
(SB-TN-62)  
3, Thiruvalluvar Thirunagar  
Karaikudi - 623 002
78. Sri. A. Madeswaram  
Block Health Supervisor  
Namagiripet - 637 420



79. Dr. P. Mahendra  
(LM)  
2, Ramachandra Road  
T.Nagar - 600 017
80. Dr. H. Mahesh Yogaraj  
(SB-TN-52)  
Mullaithidal  
Thuvarankurichi  
Trichy - 621 314
81. Dr. J. Malathi  
(SB-TN-83)  
20, 5th cross St  
Lake Area, Nungambakkam  
Madras - 600 034
82. Sri. K. Manikkam  
90, Periapatti Road  
S.P. Pudur  
Nammakkal - 637 002
83. Tmt. M. Manimegalai  
Vasudevan  
5, Kandappa Mudali Sandu  
Tiruchengodu - 637 211
84. Dr. Manimekalai  
(LM-TN-128)  
4/310, Surveyor Colony  
Algarkoil Road  
Madurai - 625 007
85. Dr. Manimekalai Murugan  
66, T.S.V. Koll Street  
Madras - 600 004
86. Dr. S. Manimekalai  
(SB-TN-54)  
II Cross, Pramasivapuram  
Lalgudi - 621 601
87. Dr. M. Maragatham  
(SB-TN-48)  
43, 8th Cross  
Thillai Nagar, Trichy - 620 018
88. Mr. S. Marappan  
32, Senkattupudu Street  
Oduvankurichi  
Namagiripet - 637 406
89. Mr. N. Marimuthu  
Health Inspector  
Nettavelampalayam  
Anangar - P.O.  
Tiruchengodu Tk.
90. Dr. S.N.S. Minnal Kodi  
(SB-TN-104)  
31, Dr. Varadarajan Street  
Vedachala Nagar  
Chengalpet - 603 001
91. Dr. M. Mohammed Kasim  
(SB-TN-45)  
51, Vandipettai Street  
Manapparai Post  
Trichy - 621 306
92. Dr. K.M.E. Mohamed Esoof  
(SB-TN-107)  
Coimbatore Municipal Corpn.  
Big Bazaar Street  
Coimbatore - 1
93. Dr. P. Mullaikodi  
(LM-TN-116)  
5 - VI th Street,  
Subramanipuram  
Karaikudi - 623 002
94. Dr. (Mrs.) Mumtaz Begum  
(SB-TN-31)  
15, Vepery High Road  
Madras - 600 003
95. Dr. A. Munawar Khan  
(SB-TN-32)  
South Street  
Kurayur, Thirumangalam Tk  
Madurai - 626 708



96. Dr. K. Muralikrishnan  
(LM-TN-138)  
3, Devarajan St  
Vedachalam Nagar  
Chengalpet - 603 001
97. Dr. S. Murugan  
(SB-TN-86)  
66, T.S.V. Koil Street  
Madras - 600 004
98. Dr. J. Muthalagan  
(LM-TN-124)  
7, Vivekananda Road  
Chetpet,  
Madras - 600 031
99. Dr. J. Mutholi  
(LM)  
Perambur Health Post  
4, Vadivelu Street  
Perambur - 600 011
100. Mr. P. Muthusamy  
Dr. Ambedkar Street  
Mallasamdrum  
Tiruchengodu Tk - 637 503
101. Dr. P. Muthuveeralakshmi  
(SB-TN-108)  
Bose Clinic,  
Samayanallur  
Madurai - 625 402
102. Dr. C. Nachammai  
(LM-TN-118)  
Alanpattu, Kallal (via)  
P.M.T. Dist.
103. Dr. N. Natarajan  
(SB-TN-93)  
582, Phase 1, H.B. Unit  
Sathuvachari  
Vellore - 632 009
104. Dr. H.K. Nayak  
(PLM)  
58-5, 4th Street  
Sector 1, K.K. Nagar  
Madras - 600 078
105. Dr. L. Neethialagan  
(SB-TN-96)  
46, Phase 1, HIG  
TNHB - Tirupattur  
N. Arcot - 635 601
106. Dr. S. Nirmala  
(SB-TN-81)  
195, Baazar Street  
Madhavaram  
Madras - 600 060
107. Dr. Noorus Syed  
(SB-TN-90)  
100, Mullah Street  
Pernambur - 635 810
108. Tmt. A. Padma  
PHC - Thirumalaipatty  
Salem - 637 404
109. Dr. G. Palani  
(SB-TN-60)  
34, Pillaiyar Koil St  
Thiruchengodu, Salem Dist
110. Dr. S. Pankajakshan Unnithan  
185/3, Kurinji Colony  
14th Avenue, Anna Nagar - 40
111. Mr. M.P. Paramasivam  
31.A, Ma.Po.C. Street  
Mallasamudram  
Salem - 637 503
112. Dr. (Mrs.) Parijatham Joseph  
(LM-TN-120) egs  
69. P.T. Rajan Road  
Narimedu, Madurai - 2



113. Dr. A. Parthasarathy  
(SB-TN-34)  
166, Park Road  
Anna Nagar Western Extn  
Madras - 600 101
114. Dr. T. Pasupathi  
(SB-TN-102)  
19, Diwan Bazar, Kalavai  
Arcot - 632 503
115. Dr. V.M. Patil  
(SB-TN-87)  
3/72, Karasampet Road  
K.V. Kuppam  
Gudiyattam Taluk - 632 201
116. Dr. Paul Kandaswamy  
(SB-TN-77)  
123, Rajiv Gandhi Nagar  
Sowripalayam  
Coimbatore - 641 028
117. Mr. R. Perumal  
PHC Kabilarmalai  
Paramathivelur Tk - 637 204
118. Pharm Products Pvt. Ltd  
(LM-TN-140)  
"Vijai", Medical College Road  
Tanjore - 613 007
119. Dr. V. Piruthivi  
(SB-TN-37)  
4, Housing Society Colony  
Viswalingapuram  
Virugambakkam,  
Madras - 92
120. Dr. K.A. Pisharoti  
(SB-TN-2)  
140 -FBlock, 5th Street  
Anna Nagar - 600 102
121. Dr. S. Prabakar  
(LM)  
49,1/6 East Arokiamatha St  
Nagal Nagar P.O.  
Dindugul - 624 003
122. Dr. K.P.M. Prabhu  
(SB-TN-38)  
92-D, P.T. Rajan Salai  
K.K. Nagar, Madras - 600 078
123. Dr. J. Prabhu Clement  
Devadoss, (SB-TN-40)  
85, G.S.T. Road  
Kadaperi, Madras - 600 045
124. Dr. H. Pramila  
(SB-TN-4)  
Bl. Subhashree Apartments  
10, Lakshmi Narasimhan Road  
T.Nagar - 600 017
125. Smt. K.V. Prema  
Rural Health Trianing Center  
Perangattur  
Tiruvannamalai - 604 402
126. Tmt. S. Prema  
B01, Ganapathi Complex  
High School Road  
Mohanur - 637 015
127. Dr. N. Premela  
(SB-TN-105)  
27, Sannathi Street  
PHC Staff Quarters  
Thirukalukundram  
Chengai MGR Dist.
128. Tmt. K. Pushpavalli  
Sector Health Nurse  
Pandamangalam  
Velur Tk. Salem Dist. - 637 208



129. Dr. L. Raghavan  
(SB-TN-97)  
4, Mahalakshmi Street,  
Thilagavatti Nagar  
Tambaram East - 600 059
130. Dr. A. Rajagopal  
(LM-TN-143)  
Main Road  
Guziliamparai P.O.  
Vadamadurai Tk.  
Dindugul Anna Dist. - 624 703
131. Dr. K. Rajendran  
(SB-TN-24)  
Director,  
Institute of Public Health  
Poonamalee, Madras - 600 056
132. Dr. K. Rajendran  
(SB-TN-44)  
Medical Officer, PHC.  
Chettikulam, Trichy - 621 104
133. Dr. C. Rajeswari  
88, Gangadeeswarer Koil St  
Purasawalkam,  
Madras - 84
134. Dr. P. Rajeswari  
(SB-TN-39)  
Professor of Health Education  
GIRH&FWT  
Ambathurai - 624 309
135. Dr. M. Rama  
(LM-TN-119)  
1, New Natham Road  
Reserve Line  
Madurai - 625 014
136. Mr. G. Ramadass  
Block Health Supervisor  
Eluru Village P.O.  
Puduchatram,  
Salem - 637 018
137. Dr. R. Ramalingam  
(SB-TN-49)  
B-17. 2nd Cross  
Thillinagar, Trichy - 620 018
138. Dr. R. Ramalingam  
(SB-TN-55)  
Dy. Director of  
Health Services  
25, LIC Colony  
East Tambaram, Madras - 59
139. Dr. A. Ramalingeishwara Rao  
(SB-TN-14)  
9, Amruthamma Colony  
S.R.P. Koil St, (South)  
Agaram, Madras - 600 082
140. Dr. N. Ramamoorthy  
(SB-TN-56)  
20, Subramania Nagar,  
Opp : Sabari Mills,  
Trichy - 621 021
141. Dr. C. Ramaswamy  
(SB-TN-91)  
No. 71/A : Bazar st  
Tiruvalam, N. Arcot - 632 515
142. Dr. D. Jagadeesh Ramaswamy  
(LM-TN-91)  
11, P.A Apartment  
31, 2nd Main Road,  
Gandhi Nagar, Adayar - 20
143. Mr. R. Ramasamy  
P.H.C., Erumapathi - 637 013
144. Ramesh Medical Hall  
(LM)  
9, Samudra Mudali St,  
Madras 600 003
145. Mr. M. Ranganathan,  
Block Health Superisor  
Veemanapalayam R.O  
Pothanur - 638 181



146. Dr. C. Ravi Chandran  
(SB-TN-73)  
2.C Old Tower Block  
Nandanam Extn, Madras - 35

147. Dr. M. Rebeca Thenmozhi  
(SB-TN-88)  
15, 6th West Cross Road,  
Gandhi Nagar, Vellore - 6

148. Dr. P. Rengaraj  
(SB-TN-75)  
29 - B\EB, Madam St,  
Kancheepuram - 631 501

149. Dr. Renukanayaki  
3, Perumal Koil St,  
Mettupalayam, Madras - 33

150. Smt. A. Renuka Devi  
Public Health Nurse,  
RHTC, Bala Chetty Chathram,  
Chengalpet Dist - 631 511

151. Sr. Rita Thyveetil  
(SB-TN-13)  
Co ordinator, (SCC - SEAD)  
P.B.NO. 395  
Old Goods Shed Road  
Theppakulam, Trichy - 620 002

152. Dr. (Mrs) D.J. Samuel,  
(SB-TN-10)  
R.M.O Quarters,  
14, Bharathi Road,  
Perambur - 600 011

153. Tmt. M. Santhi  
P.H.C., Manichampalayam,  
Tiruchengodu Tk - 637 202

154. Dr. Saraswathi Krishnan,  
(SB-TN-28)  
47, Police Commissioner  
Office Road,  
Egmore, Madras - 600 008.

155. Dr. G. Sargunam  
(SB-TN-71)  
3/3000, Vennatrangarai  
Thanjavur - 613 003

156. Mr. Sarojini Satyanathan,  
"Aishwarya"  
3A. XI Street, Tansi Nagar,  
Velachery - 600 042

157. Smt S. Sarojini  
(SB-TN-9)  
72, Thiruvallalar Nagar  
Alandur, Madras - 600 016

158. Dr. M.S. Sasikala  
Medical Officer,  
18, Pasupathy Nagar,  
Madurai - 625 014

159. Dr. Sasirekha Rengarajan,  
(LM-TN-133)  
7, Anu Apartments  
35, Circular Road,  
United India Colony,  
Madras - 600 024

160. Mr. Selvaraj  
Health Inspector, PHC  
Namagiripet, Salem - 637 406

161. Dr. M. Senthamarai Selvi  
(SB-TN-99)  
3/38, Kavasampet Rd,  
K.V. Kuppam,  
Gudiyattam Tk - 632 201

162. Dr. M. Shajahan,  
(SB-TN-68)  
22, V<sup>th</sup> Main Road,  
Jawahar Nagar, Madras - 82

163. Dr. A.K. Shamshed Begum  
(LM)  
33A, Ediga Road,  
Ambur,  
N.A District - 635 082



164. Dr. S. Shanmuganandan,  
(SB-TN-64)  
"Ishwary" Plot. No. 72,  
Pasupathy Nagar,  
Madurai - 14
165. Dr. K.V. Shantha  
(SB-TN-29)  
41, A.K. Swamy Nagar  
4<sup>th</sup> Kilpauk, Madras 600 010
166. Smt. E.V. Shantha,  
Dy Director (Trng)  
Communication  
& Training Centre,  
Taramani, Madras - 113
167. Mrs. Shantha Narayanan,  
(LM-TN-123)  
68/5 3rd Main Road,  
Gandhi Nagar, Adayar,  
Madras - 600 020
168. P. Shanti  
(SB-TN-100)  
4, Sivanar St, Tirupattur  
N.Arcot Dist - 635 601
169. Dr. G.S. Shanthi  
(LM-TN-134)  
AB-77, 1st Street  
Anna Nagar, Madras - 600 040
170. Mr. K. Shanthy  
95, Sivaji St,  
Gothi Apartments  
T.Nagar, Madras - 600 017
171. Dr. P. Shanthakumari  
(LM)  
156, M.T.H. Road,  
Villivakkam, Madras
172. Dr. P. Shanthakumari  
R.M.O Quarters,  
30, Kariappa Street,  
Madras - 600 007
173. Dr. M. Sheelakumari  
20, 2nd Cross Street,  
Indira Nagar, Madras - 20
174. Dr. Sheila Sekar,  
(SB-TN-7)  
221 - A - Anna Nagar  
Western Extn, 2nd Avenue  
Madras - 600 101.
175. P.G. Sivanandan  
(SB-TN-22)  
53, 2nd Main Road  
Gandhi Nagar, Adayar  
Madras - 600 020
176. Dr. C.S. Sivagamisundari  
(LM-TM-122)  
5, New HIG - G Flat  
A.A Nagar, Madurai - 625 020
177. Dr. V.R. Sivakumari  
(SB-TN-66)  
SRM Hospital  
West Mambalam, Madras - 33
178. Dr P. Sivaprakasam,  
(SB-TN-33)  
17, Chellammal St,  
Shenoy Nagar, Madras-600 030
179. Dr. Sivaramamurthy.  
(SB-TN-36)  
99-D-Pagampiriyal St,  
Tuticorin - 628 002
180. Dr. R. Somasekar  
(SB-TN-74)  
160, 1st Street,  
Venkateswaran Nagar  
Polichalur, Madras-600 074
181. Dr. Somasundaram  
12, Abdul Kaffar Khan St,  
Chinnachokikulam,  
Madurai - 625 002



182. Dr. P. Srinivasan,  
(SB-TN-72)  
Jt. Director (Health)  
48, L.B. Road, Madras - 20
183. Dr. N.M. Sudrasanam,  
(SB-TN-106)  
23/1 Veeraswamy St,  
West Mambalam, Madras - 33
184. Mr. J. Subramaniam  
C,4/9 TNGRHS Quarters  
Tirumangalam  
Anna Nagar West, Madras - 40
185. Dr. P.T. Subramaniam,  
(SB-TN-25)  
69, Pasupathy Nagar,  
Madurai - 635 014
186. Dr. V. Subramaniam  
(LM-TN-113)  
P.H.C., Pudukottai - 623 108
187. Dr.V. Sukumaran,  
(SB-TN-6)  
Plot 6818, Govindan St,  
Ayyavu Colony, Madras - 29
188. Dr. (Mrs) Sumathy S. Rao  
(SB-TN-3)  
Y-137, 3rd Street, 6th Main  
AnnaNagar, Madras - 600 040
189. Smt. A. Sundavalli  
RHTC-Arcot, N.A. Dist.
190. Dr. V. Sundaravadivelu  
(LM-TN-126)  
Mannalakarai P.O  
Ramanathapuram Dist
191. Dr. D. Surendranath  
(SB-TN-35)  
Dy. Director of  
Health Services,  
Peryakulam - 626 501
192. Dr. S. Suresh  
(SB-TN-84)  
C- 485,9th Street,  
Periyar Nagar, Madras - 82
193. Dr. (Tmt.) T. Susheela  
(SB-TN-30)  
H, 17, Anna Nagar East,  
Madras - 102
194. Dr. Swaminathan Natarajan  
(SB-TN-109)  
19,South Agraharam  
Tirupattur - 635 601
195. Dr. Syed Monideen,  
(LM-TN-131)  
T.S. No 2208,  
West 3rd Street,  
Pudukottai - 622 001
196. Dr. D.R. Tamil Selvi  
(SB-TN-82)  
250/3 Pioneer Colony  
Anna Nagar (W) Extn.  
Madras - 600 101
197. Dr. S. Thiliban  
(SB-TN-95)  
Jothi Hall, Jolarpettai - 636 851
198. Dr. C. Thirupathi  
(SB-TN-94)  
386, MIG, Tirupattur - 635 601
199. Dr. C. Thirugnana Sambandam  
8, 1st Block, 2nd Main Road  
Anna Nagar, Madras - 600 102
200. Dr. M. Umapathy  
(LM-TN-129)  
Menamelkudi  
Pudukkottai Dist. - 614 620
201. Tmt. P. Vasantha  
42, Natarajapuram, Illrd Street  
Nammakkal - 637 001



202. Tmt. D. Vedalakshmi  
W/o R. Gunasekar  
98. I Subramaniyapuram  
Mohanur - 637 015
203. Mr. V. Veerappan  
Block Health Supervisor PHC  
Manickampalayam - 637 202
204. Dr. V. Veerasekaran,  
(LM-TN-144)  
62, East Car St.,  
Madhan Hospital  
Palani - 624 601
205. Dr. C. Velmurugan,  
(SB-TN-57)  
33.A/2, Raman Pillai St.,  
R.V. Puram - Nagercoil
206. Dr. (Tmt.) Vijayasrinivasan,  
(SB-TN-69)  
Institute of Research in  
Medical Statistics,  
Chetpet - 600 031
207. Dr. Vijayachandra Booshnam,  
(L.M)  
6, Edigar St.,  
Krishnapuram,  
Ambur - 635 802
208. Dr. Vijayalakshmi  
(LM-TN-135)  
P.H.C., Arasanur  
Sivaganga Dist.
209. Dr. N. Vijayaragavan  
(PLM)  
Addl. Director of Public Health  
259, Anna Salai,  
Madras - 600 006.
210. Dr. K.C. Viswanathan  
(S.B-TN-63)  
14, Alapakkam, Vallarn Post,  
Chengalpet - 603 002
211. Dr. Vittal Raj  
(SB-TN-61)  
49, 3rd Main Road,  
Raja Annamalaipuram,  
Madras - 600 028
212. Dr. M.A. Wahida Banu  
65 F, Beracah Road,  
Kellys  
Madras - 600 010
213. Dr. Yashodha Dominic  
7, Buckingham Garden  
Stephenson Road,  
Perambur, Madras - 600 012

---

**(Members are requested to bring to notice of Secretary TAMSEARB\* any discrepancies in the spelling, address or Life Membership)**

\* Dr. Sumathy S. Rao, Y-137, 3<sup>rd</sup> Street, 6<sup>th</sup> Main, Anna Nagar ,  
Madras - 600 040







# INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION

South East Asia Regional Bureau

## APPLICATION FOR MEMBERSHIP

1. Name .....

Wishes to apply for admission as a

(a) Life Member  
(Rs. 1000)

(b) Individual Member  
(Rs. 100/- annum)

2. Address : .....

3. Town ..... 4. Postal Code ..... 5. Country .....

6. Profession / Health Education and IEC activities engaged in  
.....  
.....

7. Wish to participate - receive information :

- on the National / Regional / International conferences on Health Education./ On study tours./ Other activities.

8. Wish to receive technical publication's such as 'HYGIE' 'SEARB' Bulletin, etc., in English

9. Enclosed a cheque for ..... drawn in favour of International Union for Health Education - South East Asia Regional Bureau.

Name of Bank .....

Cheque No. .... Date : .....

*Signature of Applicant & Date*

To :

Regional Director, IUPHE, SEARB, 6, V.R. Road, Madhava Nagar  
Bangalore - 560 001, India



# INTERNATIONAL UNION FOR HEALTH EDUCATION AND EDUCATION

## APPLICATION FOR MEMBERSHIP

I hereby apply for admission as a

Full Member

for 1955

The following is my  
present address

Name ..... 4-Postal Code .....

I am a member of the Health Education and EC societies engaged in

which is to participate in the following

on the following / Regional / International conferences on Health  
Education / On study tours / Other activities

I am a member of the following societies such as HYGE, SEAR, etc. in English

I have a degree in ..... from the University of .....  
I am a member of the following societies such as HYGE, SEAR, etc. in English

Signature of the applicant

Date

Signature of the Secretary

General Secretary: H. SEAR, 100, Rue de la Paix, Paris  
Telephone: 501 10 10



## **Publications of TAMSEARB**

Proceedings of the first South East Asian Regional Conference (Education for Better Health of Mother and Child in Primary Health Care.) 1986 (Pages 615)

Innovative Approaches to Training of Health and Allied Personnel in Primary Health Care. 1990 (Pages 122)

Bulletin and Souvenir of the 3<sup>rd</sup> Regional Conference of SEARB (People's Involvement in Health and Development in Women and Children.) 1994 (Pages 593).

limited number of copies of these are available with the Secretary of  
e TAMSEARB, at Y-37, Annanagar, Madras 40.



# **HELP**

**in Health Improvement by  
Empowering People Through  
Appropriate and Adequate Education**



**IUHPE and SEARB help in  
this. Strengthen IUHPE by  
Enrolling Yourself as Member**